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**ABNORMALLY LARGE SUPERIOR STRAIT, A COMPLICATION OF LABOR.**

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At first sight such a statement would appear a contradiction, for with apparently greater facility of exit, one would expect more rapid delivery. The following six cases, however, while too few to make the statement a truism, go far to establish its correctness.

The six patients referred to below were all ladies simply exercising household supervision, and doing no manual labor. They were also all primiparæ.

**CASE 1.** Mrs. T—, at. 24, a tall, slender blonde. Labor commenced Aug. 11, 1871. Vaginal examination revealed the head presenting, enclosed in the womb, and resting upon the perineum; os tincæ moderately far back towards coccyx, and undilated; uterine contractions energetic, frequent and regular, and exceedingly painful. No progress being made during several hours, nauseating doses of tartarized antimony were administered, and subsequently  $\frac{1}{2}$  gr. morphia hypodermic.

mically. Under the influence of the opiate, the uterine os was brought forward and dilated, and the membranes ruptured. The first stage of labor had lasted twenty-four hours, the second stage was completed in two hours.

In this case there was but little obliquity of the womb. The os tincæ was dilatable but did not dilate. No bag of waters formed.

**CASE 2.** Mrs. H—, æt. 23, undersized, slender blonde. Labor commenced about term, July 19, 1872, caused by the unexpected breaking of the waters during sudden fright. Vaginal examination revealed the uterus very low down in pelvis, os tincæ far back in hollow of sacrum; vertex presenting; patient hysterical, with feeble and irregular uterine contractions. Administered  $\frac{1}{2}$  gr. morphia hypodermically. After a sleep of six hours uterine expulsive pains came on regularly and energetically, and continued so for seven hours, when delivery was accomplished. Child weighed  $4\frac{1}{2}$  pounds.

In this case, owing to accident, there was no first stage of labor. The second stage was evidently prolonged through seven hours, by the low position of the womb. The uterine os, though flaccid, would not dilate, and the strong pains seemed to have no expulsive power. The use of forceps was forbidden.

**CASE 3.** Mrs. K—, æt. 28, slender, medium-sized blonde. Examination of urine thirteen days before labor showed no albuminuria. Labor commenced Oct. 8, 1873. Vaginal examination revealed uterus enclosing foetal head resting upon perineum, os tincæ easily reached and dilating. Labor progressed favorably for four hours, when, without warning, a severe convulsion occurred; patient immediately bled about twenty ounces, and delivered with forceps. One-half grain morphia then injected hypodermically. Made a good recovery.

In this case, the patient was extremely small during pregnancy, even at term giving scarcely any external evidence of her condition. This was due to the low posi-

tion of the womb and the absence of any obliquity of the organ. Had convulsions not occurred, delivery would have soon been accomplished naturally. The extreme and unnatural descent of the womb, however, undoubtedly caused pressure upon the ureters, and produced the uræmia and convulsion. Albuminuria existed for several days after labor, and the urine was loaded with uric acid crystals.

**CASE 4.** Mrs. McD—, æt. 25, a full-sized brunette. Labor commenced April 7, 1875. Vaginal examination revealed foetal head within uterus resting upon perineum, os tincae not to be felt; uterine contractions strong, frequent, regular, and very painful throughout labor. Persistent effort at last engaged two fingers in the uterine os, which was brought forward between the pains. As soon as sufficiently dilated, the membranes were ruptured and the labor completed. First stage of labor, eight hours; second stage, two hours.

In this case, the same conditions, of dilatable but undilating os, and non-expulsive though severe pains, existed.

**CASE 5.** Mrs. S—, æt. 21, slender brunette. Was called in ten days before labor on account of extreme general dropsy. Examination of urine revealed small amount of albumen. Prescribed 3 drachms daily, of bitartrate of potassa largely diluted, and full doses of quinine and iron. Labor commenced May 3rd, 1875; at that time dropsy much diminished and no albuminuria. Vaginal examination revealed the same conditions as in Case 4, and the labor was in every way similar, the first stage lasting twelve hours, and second stage two hours.

In this patient, we have the conditions existing in Cases 3 and 4, viz.: dilatable but undilating os; strong but non-expulsive pains; and compression of the ureters, producing dropsy and albuminuria.

CASE 6. Mrs. E—, æt. 26, medium-sized, slender brunette. Was called to see this patient thirteen days before labor on account of extreme general dropsy ; her face, neck, hands and lower extremities were largely oedematous, and the genitalia so swollen as scarcely to admit of vaginal examination. For the few last days had suffered from dizziness and momentary attacks of blindness ; was also asthmatic ; the urine a few days before had been tested and found normal ; some, now drawn off, was found to be largely albuminous. Prescribed iron and quinine, and drinks of solut. bitartrate of potassa. Nov. 30, 1875, labor commenced ; at this time the dropsy, especially of the genitalia, was still enormous and the urine albuminous. Vaginal examination discovered the foetal head, within the womb, resting upon the perineum, and the os tincæ far back in the hollow of the sacrum. As labor pains had already existed twenty-four hours and patient was restless and nervous, I administered, per orem, 45 grs. chloral hydrate ; assisted by its influence the uterine os was brought forward. The foetal head was then allowed for six more hours to drive upon the perineum, to expel, if possible, the oedema ; a slight convulsion then occurred ; 30 grs. additional hydrate of chloral were administered, the membranes ruptured and forceps applied ; a living child was delivered, and the perineum lacerated to the sphincter ani. For six days subsequently there was retention of urine, requiring the daily use of the catheter. Duration of first stage of labor, thirty hours.

In this case, the vilest I ever attended, there were the same conditions of dilatable but undilating os, and severe and painful but non-expulsive uterine contraction.

In reviewing these cases, two things are noticeable :

1. The increased length of the first stage of labor.
2. The albuminuria which complicated one-half of them.

1. The prolongation of the first stage of labor is traceable directly to the non-expulsive character of the

pains, and the non-dilatation of the os tincæ; and indirectly to the abnormally large diameters of the superior strait.

Without entering into particulars, it may be said of a labor pain, during a strictly normal labor, that the circular uterine fibres by their contraction diminish the transverse diameters of the womb, while the longitudinal fibres by synchronous contraction diminish its long diameter. In this way the waters are forced down into the cervix, upon the protruding membranes, to dilate the external os, at the same time that the womb, fixed upon the body of the child, tends to draw itself up over the foetal head, thus making the pain expulsive. In other words, the contractions of the circular fibres are mostly compressive and tend to drive out the waters, while the contractions of the longitudinal fibres, using the fundus as a fulcrum, are mostly expulsive and tend to drive out the child. Both tend, during the first stage of labor, to dilate the os tincæ, and a successive repetition of them finally ruptures the membranes and completes this stage of labor.

In the class of cases under consideration, however, a different condition of things exists. The womb has descended low into the true pelvis. When now a uterine contraction occurs, the longitudinal fibres caught midway between the foetal head and the pelvic brim are strongly compressed and fail to contract. Thus the long diameter of the womb is not diminished, and the pain is not expulsive. This annular compression of the uterine walls is extremely painful, and thus arises another factor in restraining the expulsive force of the contractions. In the six cases reported, each patient complained of agonizing pain with each uterine contraction, located principally in the groins and back. It was impossible to bear down, or in any way to assist by voluntary effort the labor of the womb.

The non-dilatation of the os tincæ can now readily be accounted for. The longitudinal uterine fibres which

should expand it over the foetal head are powerless, at the same time the circular fibres are active and render it rigid with each throe of parturition. Still further, two mechanical obstacles effectively prevent the formation of a bag of waters. The foetal head, accurately fitting the superior strait, lined, as it is, with the muscular tissues of the womb, prevents all egress of amniotic waters, and holding the os tincæ firmly against the perineum or in the hollow of the sacrum permits no protrusion of the membranes. These are the reasons why, in all the cases above recorded, the os was invariable in its rigidity and small orifice during the uterine contractions, however dilated and relaxed it may have been in the intervals between the spasms.

With such results, it is not difficult to go back to the remote cause, and see how an abnormally large pelvic brim can render the first stage of labor tedious and painful.

2. I take it, however, that there is a much graver complication of labor growing out of this condition, namely: albuminuria, with or without general oedema.

Of the six cases reported, 50 per cent. had albuminuria and 33½ per cent. eclampsia. The per centage is suspiciously large. It is, however, more noticeable, when it is considered that these six cases are the only ones of the kind in 185 recorded cases of labor, and that in these 185 cases there were but six cases of puerperal eclampsia (a large proportion). In other words, one-third, or 33½ per cent., of all the cases of eclampsia in 185 labors, could apparently be traced to an abnormally large superior strait, and a low position of the gravid womb in the true pelvis. I know that the number of labors is too small to furnish accurate and positive conclusions, but as before said, the percentage is suspiciously large. One could reasonably suppose that the position of the womb had much to do with the albuminuria and convulsions.

If the commonly received opinion be true, that renal congestion be due to direct compression of the kidneys or of the renal veins, one would suppose that, with a womb so low in the pelvis, such pressure would be at a minimum, and would reasonably expect a decreased tendency to albuminuria—a conclusion exactly the reverse of true. Again, in all pregnant women there is always a certain average amount of pressure from the gravid womb upon the abdominal contents. Why then should one escape albuminuria more than another? The question becomes more pertinent when we find that those with uteri abnormally large at term, have no special tendency to nephritic congestion, unless from downward pressure œdema is superadded. Indeed, to my mind it is doubtful if nephritis often originates in this manner. The spinal column is so prominent in the abdominal cavity, that it must receive to a large extent the full force of the backward shove of the uterus; while the kidneys, spared through the globular shape of the womb, and their own encasement in adipose tissue, lie safely in the hollows each side of the spine. Further, the inferior vena cava lies to the right of, and below, the prominence of the spine. Thus the right renal vein is safe from pressure, while the left, crossing the spine above the summit of its forward lumbar curve, can scarce be compressed by the convex fundus, owing to the obliquity of the womb forwards.

I prefer to think, that albuminuria is oftenest caused by pressure upon the ureters; either as they escape over the brim of the pelvis, or as they discharge themselves into the bladder, thus obstructing the outflow of urine, and starting backward the train of symptoms whose frequent culmination is eclampsia. The comparative rarity of puerperal convulsions, and their special predilection for primipara, can thus, I think, best be accounted for.

The conditions most favorable for such compression are found in the six cases reported, and while these cases are but about three per cent. of the recorded labors from

which they are taken, they furnish over thirty-three per cent. of the cases of eclampsia.

Finally, the six reported cases were all primiparæ. In such, similar conditions exist for the compression of the ureters beyond what is found in multiparæ, but from a different cause. It would be a mistake to suppose that the resistance to the growing womb of the firm and unrelaxed abdominal walls was only, in direction, from before backward. It is rather from every side inward and downward, thus keeping the womb wedged into the brim of the pelvis, and directly pressing upon the ureters as they escape into that cavity.

No. 16 LOOMIS ST.

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### KATHERINE HOHMANN.

A DESCRIPTION OF THIS REPUTED HERMAPHRODITE.

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This person, who has been exhibited before the Chicago Society of Physicians and Surgeons, by Prof. Byford; and by myself made the subject of a recent lecture at the Rush Medical College, has for many years been known as an instance of bisexual hermaphroditism. He has also been exhibited before many distinguished medical gentlemen of Europe, and been frequently described in medical literature.\*

It will be proper to speak of this creature as being of the masculine gender; inasmuch as he is now a husband, and comports himself in all respects as a male; and because a careful external examination, and interrogation, fail to elicit a single attribute belonging strictly to the feminine sexuality.

He is now fifty-two years of age, was born in Germany,

\* Hermaphroditism, From a Medico-Legal Point of View. By Basile Poppesco. Translated from the French by Edw. Warren Sawyer, M.D. W. B. Keen, Cooke & Co. Chicago, 1875.

and christened Katherina. This name he bore till two years since, when, by a decree of the German court, it was changed to Charles. He was reared as a girl ; and, as he now asserts, more than once copulated as a female. Menstruation began before the age of twenty, and recurred with measurable regularity. Nothing unusual was noticed in his sexual conformation till the age of thirty-six, when, on account of a strangulated inguinal hernia, he says, he was seen by Simon, of Heidelberg, who operated. Attention was then drawn to his sexual mal-formation ; and it was decided that he belonged to the male sex, rather than to the female. From that time he has worn the habiliments of the male. At the age of forty-four, menstruation ceased. The organs which mark him as a male now took on a rapid growth, and soon became a third larger than before. About two years since, he married his present wife, now twenty-six years old ; who was advised to escape the dangers of child-bearing, on account of a deformed pelvis. His marital privileges are now so well assumed as to call forth from his wife the highest encomiums. His predilections have always been for the woman. The foregoing is substantially his history, which has been elicited from himself and his companion.

His statue is that of a medium-sized man. The feet are rather small ; but the hands are large. The extremities on the right side have a circumference a trifle larger than the left extremities. His right eye is noticeably larger than the left, and of a different shade ; while the left pupil is larger than the right. The skin is decidedly less fine than that of the female, and it seems even coarser than that of the cleanly male. His dark hair is very thick, and reaches nearly to his shoulders. His figure is rather a compromise of the male and female ; though it has been remarked that the ilia were rather projected outward. The loins and waist are decidedly masculine. His carriage is rather feminine ; perhaps on account of his being attired so long as a female. The entire surface is well supplied with hair follicles ; the pubic hair extends

upward along the median line as far as the umbilicus, as it usually does in the male ; and is not abruptly limited, just above the symphysis pubis, as in the female. Moreover, the chin and upper lip are thickly studded with beard, and the sides of the face sparsely so, which is regularly shaven. His axillæ are supplied with hair, and the anus is also surrounded with hair. He has two, well-developed, rather pendulous mammary protuberances ; these are surmounted by large, projecting nipples, resting on small, dark, reddish-brown areolæ ; the latter are studded with hair.

Concerning the genitalia : On the right side there is a small scrotum, corrugated and covered with hair ; in all respects this pouch is quite like the right half of the male scrotum ; it encroaches somewhat upon the left side. In the scrotum a good-sized testicle, with its epididymis and vas deferens, can be easily established. On the left side there is no projecting fold suggestive of the scrotum or labium ; the surface is here covered with hair. In the normal situation there is a penis which, in the lax condition, measured along the dorsum, is about three inches in length, and of average volume. The penis terminates in a well-formed glans, which is covered superiorly by a lax cutaneous fold like a hood. The virile organ is said to assume a length of six inches during sexual excitement ; it does not project outward ; because, on account of the absence of the anterior half of the corpora spongiosa, the organ seems to be bound down inferiorly. The bulbous portion of the spongy bodies can be easily made out beneath the penis. Along the dorsum of the penis, there are two, slightly projecting cutaneous folds, with an indurated edge which, in the lax condition, is thrown into many plicæ. These folds converge, and nearly meet at the root of the penis ; at this point the skin is so lax that it can be easily lifted from the penis ; the folds then strongly resemble the nymphæ of the female. The right nymphæ is as large as the left. There is a hypospadiac slit beneath the glans penis, about a half inch in

length. If a sound is placed in this slit, and directed downward, it enters a round opening having the size and appearance of the female meatus urinarius. This opening looks upward, and is on a plane anterior to the root of the penis ; it is brought to within an inch of the end of the organ by the turning downward of the penis. It is through this opening that the catamenial blood is said to have escaped, and through which he copulated as a female ; and which now gives exit to the urine and the liquor seminis. The sound introduced into this meatus can be passed downward about an inch (the subject being in the sitting posture), when it is arrested, and seems separated from the finger externally by a thin septum. If the handle of the sound is now depressed, the instrument passes backward, and slightly upward, some two inches ; it does not enter the bladder, for no urine flows through a catheter thus introduced. The subject does not permit any farther examination with the sound.

In the left groin there is an oval-shaped body, as large as a pullet's egg. This body is movable ; and when seized between the fingers is painful, giving him a sensation which he likens to that which he experiences when his testicle is squeezed. I failed to find any evidence that he had ever submitted to a cutting operation for the relief of a strangulated hernia.

Relying upon the foregoing, which is all that can be elicited from an ordinary examination, the question may well be asked : Is this, indeed, an instance of androgynia, (the association of the essential male and female organs in the same creature,) and not a mal-formed man, with cryptorchidia and hypospadias ? It seems to me, that, from this examination alone, one is forced to decide upon a male sexuality. Even the presence of the pendulous mammae does not preclude this ; for instances are known of men who have had mammae sufficiently developed to afford nourishment to a child.\* Especially has

\* Vide Flint's Physiology of Man, Vol. 3, page 73. D. Appleton & Co. New York, 1870.

this unusual mammary development been noticed if the male is the subject of cryptorchidia, or has been emasculated in early youth.

The supposed female sexuality of this creature is founded solely upon the assumed menstruation. There can be no doubt but that he is thought to have menstruated; for in the scientific description of him in the *Lo Sperimentale*, referred to by Poppesco,\* the function of menstruation is assumed to have existed. Moreover, men as eminent as Recklinghausen, Kölliker and Scanzoni, are reported to have said that they have seen blood escape from this man's urethra; and that this blood possessed all the microscopical appearances of catamenial blood.

A doubt has been raised by some as to the possibility of copulation being accomplished through this narrow meatus. The fact that there are authenticated instances of the female urethra being the habitual avenue of copulation, should protect this man's assertion from total discredit.

But in view of the facts: first, that this creature does possess the essential characteristics of the male—for his semen, which has been examined by Virchow, contains numerous spermatozoids; second, that there is a possibility that the blood which escaped periodically from the urethra may not have been true menstrual blood—for this creature soon realized that he was the subject of great wonder, and might have easily inflicted some slight wound of the canal, sufficient to have produced an oozing of blood; moreover, the microscopical appearances of menstrual blood are, by no means, thought by all to be distinctive. In view of these facts, I say, it seems more rational to call this a mal-formed man, with hypospadias and incomplete cryptorchidia. Or, at most, we must allow this creature to remain unclassed, until a *post-mortem* examination shall establish, beyond doubt, the presence of the essential organs of the female, the uterus or the ovary.

\* Poppesco, op. cit., page 40.

CASES OF ECCENTRIC EPILEPSY FROM IRRITATION  
OF THE GLANS PENIS.

By W. R. McMAHAN, M.D., HUNTINGBURG, IND.

The causative agent in each given case primarily is either centric or eccentric. In the former we suppose that there is, and has been, some subtle molecular change in the nerve cells in the region of the base of the brain, and this change is of such a nature, degree and intensity as to assume the full rounded form of a cause, fully adequate to the production of epilepsy. But it is to the eccentric causes of epilepsy that I wish to direct attention ; and here we find that we are not thrown, in all cases, on the unguided drift of supposition, as in the former (centric causes) ; but that we can often localize and demonstrate the causative agent, and, as such, disrobe it of its power, or remove it from the temple it is despoiling.

But we will proceed to the enumeration of the stereotyped eccentric causes, as follows : "Mechanical injuries to some sentient nerve, or its inclusion in the contraction of a cicatrix ; irritation of the intestinal canal from worms or indigestible matters ; and a morbid condition of the genital organs." These, in their broadest sense, constitute the principal eccentric causes. "Cases arising from the first enumerated cause may occur at any age." Cases arising from the second have been, and I think rightly too, confined to the age of childhood ; but the cases arising from a morbid or irritated condition of the genital organs have been, as I conceive, erroneously confined to the age of puberty, and excluded as a causative agent in the epilepsy of children, where it yields a large per centum of cases.

My attention was first called to this subject by the report of Prof. Sayre, to the American Medical Association, of a number of cases of reflex paralysis caused by the irritation arising from phymosis and adherent prepuce to the corona of the organ. And then, reasoning

from analogy, I came to the following conclusions: That if this abnormal condition of the genital organs could, and had, produced, in a given number of cases, anæmia of the spinal cord, and, as an effect of that, paralysis of the inferior extremities, the same cause might, and most probably would, in a certain number of cases, produce epilepsy, or any other nervous manifestation that is susceptible of having an eccentric origin.

Again, Sir Thomas Watson, in speaking of the causes of epilepsy,\* enumerates: debauchery of all kinds; the habitual indulgence in intoxicating liquors; and, above all, the most powerful predisposing cause, not congenital, is masturbation. Sir Charles Locock attributes the great increase of the disease, during late years, to the last named cause.

Now, if these opinions of these great men are correct, that masturbation will produce irritation of the sentient nervous system sufficient to produce epilepsy in the adult, then we are forced to the conclusion that irritation of the genital organs, in a greatly diminished degree, would produce epilepsy in childhood, a time when the over-sensitive nervous system stands trembling on the brink of convulsions, only awaiting a slight jar or nervous discord to precipitate an attack. Now, the irritation arising from phymosis, or the accumulation of smegma behind the adherent bands of the prepuce in the male, or from an abnormal condition of the genital organs in the female, producing a degree of irritation equal in intensity to that of phymosis or adherent prepuce in the male, is, in my opinion, fully adequate to produce epilepsy in childhood.

The foregoing conclusion I consider verified in the following two cases:

CASE I. C. D., a well-developed, round-faced, good-looking boy. His parents state that he was in good health until January, 1874, when, without any premonitions whatever, he was seized with a severe convulsion, characterized by perfect loss of consciousness; a con-

tracted, trembling condition of voluntary muscles; grinding of teeth, and foaming at the mouth. This condition lasted from one to two minutes, when relaxation commenced, which merged into stupor of several hours duration, when he awoke rational. His penis was now noticed to be erected, and on examination (by his parents), found in an irritated condition. He had several seizures during the first two days, and then none for several weeks, when the cycle was repeated.

This order of activity and repose continued unabated under the bromides and various other forms of treatment, until April, 1875, at which time, his parents state, his penis was in a state of irritation, and that considerable pus escaped from the preputial orifice, after which his convulsions ceased in the main, leaving only a light "*Petit mal*" variety, separated by long intervals.

On December 22, 1875, I examined his genital organs, and found a long redundant prepuce, and partial phymosis. The prepuce was retracted over the corona with great difficulty. After its retraction, the crease behind the corona was found in a suppurating condition. On the sides of the corona were suppurating spots, marking the site of former adhesions of the prepuce to the corona. The entire crown of the organ was in a red, irritated condition, but contained no imprisoned smegma or pus.

After the examination, I ordered the prepuce retracted once each day, parts cleansed, and then sponged with some mild astringent. At this time his father states that the irritation has subsided, and that there are no symptoms whatever of epilepsy.

The analysis of this case I conceive to be this: At the time of his first seizure, there was either adhesion of the prepuce to the corona of the organ, or the prepuce enveloped the crown so closely that the heretofore accumulated smegma (and perhaps pus) could not make its escape, acted as a foreign body, irritated the sentient nerves, and through these the convulsive centre or centres. That this condition continued until last April, when the adhesions or resistance gave way before the imprisoned

matters, and they made their escape ; these sentient nerves were no longer teased ; the cause was removed, and the boy recovered.

CASE II. Chas. Fisher was attacked with epilepsy on April 7, 1874. Up to that time he was a well-developed, good-looking, bright boy, and enjoyed uninterrupted good health. His attack was of a sudden character, and not preceded by any premonitions ; marked by about the same characteristics as the former case, as regards the frequency, duration and intensity of the attacks ; and this order continued, in modified form, under large doses of the bromides, and other treatment that seemed to be indicated, until the 27th of December, 1875.

On December 21, 1875, I examined his genital organs, and found firm adhesions just behind the meatus urinarius ; and on Dec. 27, 1875, I separated these adhesions and retracted the prepuce, behind which was imprisoned smegma in considerable quantity, and the parts were in a state of irritation.

From the date of his attack until this time, he had gradually grown dull and listless ; was clumsy, irascible, and his eye, at times, generally preceding his attack, would assume the appearance of a fish's. His parents state that before, during and after these groups of convulsions, he would complain of his penis, and that it was often in a state of erection. After the breaking up of adhesions over a month ago, all medication was suspended, and at present he is well ; has not had a single symptom of a convulsion since ; has regained his former activity, and his eye its wonted expressiveness. The change in his condition is so great that I have no fears of a return of his trouble.

I regret that I did not make an ophthalmoscopic examination of his eyes prior to operating, and at a time when his eyes wore a "fish-like" appearance. This appearance of these organs must have depended on a departure of the circulation from a normal standard, dependent on disturbance of the sympathetic system.

## INTRA-CAPSULAR FRACTURE OF NECK OF FEMUR.

By T. J. MAXWELL, M.D., OLENA, ILLINOIS.

(Read before the Military Tract Medical Society, Jan. 11, 1876, at Galesburg, Ill.)

I wish to lay before this Society a single clinical observation upon a subject that Sir Astley Cooper put to rest more than half a century ago. I refer to the subject of fracture of the neck of the thigh bone within the capsular ligament. As my case, in its treatment and results, conflicts with the teaching and experience of the great master, I approach the subject with the most profound respect for his genius and great learning, and hope you will not think me presumptuous.

Sir Astley doomed every man and woman who should be so unfortunate as to suffer from a fracture within the capsular ligament of the femur to a life of halting and deformity. Indeed, such was his experience without exception, and such has been generally that of the profession since his time.

With these prefatory remarks, I proceed to give the history of a case that came under my observation, the method of treatment, and its results, together with some remarks on the subject.

Mrs. J. G.—, æt. 50, on the morning of Jan. 14, 1871, slipped and fell upon the hard, icy ground while attempting to go up a short inclined plane, striking on the right hip. She said she felt somewhat stunned, but did not suspect any serious injury until she attempted to rise, and then discovered that she was unable to use her right leg. She immediately called for assistance, and was carried into the house and laid on a pallet on the floor, where I found her about one hour after the accident.

On examination, I found the foot of the injured side everted, lying on its outer edge. Free motion of the limb in every direction, rotation and flexion of the thigh upon the pelvis, could be accomplished without trouble

or the application of much force, though with considerable pain to the patient. By measuring the limb from the anterior superior spinous process of the ilium to the internal malleolus, it was discovered that the injured leg was fully one inch shorter than the other.

The leg could easily be extended to its full length, and on rotating a little in that position crepitation was developed. The lady was of thin, spare habit, and afforded an excellent opportunity for free examination about the articulation. I could grasp the trochanter major in its entire extent to the neck of the bone, and follow all its movements. There was but little swelling, and a moderate degree of pain on handling. One marked feature of the appearance and feel of the hip, was the flattening in the region of the trochanter major, which was in no way improved by extending the leg to its full length. Grasping the trochanter and rotating the leg showed that it did not describe the arc of a circle like the uninjured one, but rotated on its own axis, or nearly so. I applied Day's splint for fractures of the thigh. Had no trouble in getting the leg to its normal length; but that flattened condition of the trochanter was unchanged, and she complained of pain and uneasiness in the region of the hip and groin constantly.

I continued this appliance for ten days, and then determined to change, as it did not accomplish the purpose, that is, to keep the parts in coaptation.

Accordingly, the splint was removed, and the following treatment substituted: A pulley was fixed to the foot of the bed, and another to the side about the centre. The foot was elevated about nine inches on the front and about six on the back, and the front side of the head about three, so that the tendency of a person lying on the bed would be to slip to the head and back part. The patient was then placed in bed, and extension made by means of a weight attached to a cord passing over the pulley at the foot of the bed, and fastened to the ends of the adhesive straps which extended beyond the heel.

These adhesive straps were applied to the whole length of the thigh and leg, and, of course, covered by a bandage from the toes to the body. The lateral extending bandage, about four inches wide, was then passed around the thigh close to the body, and fastened to a cord which was carried over the pulley at the side of the bed, to which was suspended a tin bucket for weights. Weights were gradually added to the bucket at the foot until the leg was brought and kept at its normal length, and the lateral extension was increased, until the trochanter major could be grasped by the hand and felt to be as prominent as that on the well side.

The weight required to accomplish extension was about twenty pounds. For lateral extension—to lift the trochanter from its position against the posterior lip of the acetabulum—about twelve or fourteen pounds.

As soon as the lower fragment was brought out to its proper position, all pain ceased, and was not afterwards complained of during the long term of confinement.

She remained in bed with this apparatus until the fourteenth day of March, just two months to a day from the date of injury. When it was removed, motion and adhesion of the part appeared perfect. The adhesive straps, by which extension was secured, caused some slight abrasions of the skin; the knee joint was swollen and painful, and it was several weeks before it resumed its function so as to be useful.

The leg maintained its normal length at the time of the removal of the dressing, and the lady walks to-day with the least perceptible halt.

I claim no originality for this mode of treating this kind of fracture, as the plan was fully set forth and illustrated by a wood cut, in a late number of the *American Journal of Medical Sciences*.

I venture to ask, may it not be more the inability of the surgeon to maintain the fragments in coaptation—as Prof. Gross states that no means yet known to the profession accomplishes this perfectly—rather than a

physiological impossibility for the parts to unite by bony union, as claimed by Sir Astley Cooper? Had I followed that great master in the treatment of my patient, she would have undoubtedly become a cripple, and gone halting the balance of her life.

I do not think it possible to have had as good results follow the first appliance in this case. If by this report I shall induce the members of this Society to investigate the subject, and prove it good or bad, my object will have been fully accomplished.

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#### GANGRENOUS ERYSIPELAS.

BY M. A. McCLELLAND, M.D., KNOXVILLE, ILL.

(Read before the Military Tract Medical Society, Jan. 11, 1876, at Galesburg, Ill.)

**CASE 1.** Mrs. Hamerstrom, aged 50 years, while digging potatoes, wounded her foot very slightly with the tine of a potatoe fork. Three days after I was called in to see her, and found the foot swollen, hot, red and tender. At a point near the ankle, and at another near the seat of wound, there were appearances that led me to suppose one or two abscesses were forming. I the more readily made out this diagnosis, as the tissues were very tense, and did not pit under pressure.

Directed a saline cathartic, and applied locally lead water and laudanum.

The next morning the redness was more intense, and had extended up the limb two-thirds of the way to the knee ; foot pitting.

Directed, the salts having acted well, tincture iron and quinine, gtt. **xx**, gr. **ij**, every three hours. Limb to be painted with tincture iodine ; lead water and laudanum continued ; morphine. Third day, a large blister had formed upon foot and ankle. Stopped local applications of iodine, lead water, etc., and directed a solution of

pot. permanganate 3 ij, ad aq. 3 j, with which foot was to be constantly wet.

The discharge from the wound, and also the contents of the blister, were a thin, watery fluid, containing flocculent, grayish matter. Morphine continued, to procure sleep and allay pain, which, however, at no time was very severe.

4th day. Foot and limb, as high as the knee, blistered. The surface around ankle, which first blistered, is becoming gangrenous. Quinine and iron continued. Limb to be kept constantly wet with solution of pot. permang.

5th day. Gangrene extending. A dense, gray slough forming at bottom of blisters. Treatment continued, with addition of egg-nog.

7th day. Gangrene does not spread. It now includes all the external half of the dorsum of foot from around the ankle to the toes. Several smaller patches upon the inside of the dorsum. Deep, grayish sloughs have cut off small islands of semi-healthy tissue, and are undermining them. Several have been thus separated from below, and lie upon the sloughs as black, fleshy masses. Saturated solution of bromine applied every hour. Iron and quinine continued, also stimulants and concentrated nourishment.

9th day. Sloughs separating. Red granulations appearing at edges of ulcers. Treatment continued.

12th day. Sloughs being thrown off in large masses. Dorsalis pedis lies uncovered for the space of an inch, and is covered with healthy granulations. Locally a weaker solution of bromine, the parts to be first cleansed with pot. permang. 3 j, aq. 3 j.

The above patient was an enfeebled, broken-down woman. Her hygienic surroundings were pretty good. The case was marked throughout by a very regular circulation, and with but slight febrile manifestations. Pulse never went to a hundred. Tongue remained moist throughout. No delirium. Prognosis now is quite favorable.

CASE 2. S. M., aged 52 years. Was called to see patient July 31, 1875. He gave the following commemorative history: Was pitching hay during the week, and one day, while it was raining, he went to sleep in the hay mow, and slept most of the afternoon. Woke up with headache and a good deal of pain about the left pectoral muscle. Headache and pain still continued, in addition to which he was now feverish; anorexia marked; no chills. Had taken some pills, which had operated.

I found him with a dry, red tongue, pulse 90 per minute, somewhat feverish, and with considerable soreness in left pectoral muscle. Diagnosed a threatened attack of typho-malarial fever, with perhaps some rheumatic trouble about pectoralis.

Left him bromide of potass. for headache, and quinine gr. v. every three hours. He was to have his clothing and bed-linen changed every day, and to be well sponged off with water of such a temperature as was most agreeable several times a day.

I saw him again the next day, and found no change. Treatment continued, with the addition of acid. sulph. aromat., ten drops with each quinine powder.

Saw him again August 3d, when I found him free from headache. Soreness had left breast and had settled in the left lumbar region, which, upon examination, was found to be swollen. He was directed to poultice the part and continue the quinine and acid in smaller doses. Was not to see him again till the 5th, but on the morning of the 4th he sent for me on account of retention of his urine. He had taken gr.  $\frac{1}{2}$  of morphine the night before, for the purpose of promoting sleep. I introduced a No. 10 catheter and drew off a quart of water, which presented a healthy appearance, except it was slightly darker than normal. Treatment continued, with the addition of a mild cathartic. Lumbar abscess diagnosed.

On the 5th of August cathartic had acted. Appearance of an abscess more marked.

Dr. Reece, of Abington, Ill., was sent for and saw him

the morning of the 6th, and confirmed the diagnosis. Advised iron to be added to quinine. Patient's urine had still to be drawn with catheter. The sense of fluctuation was very obscure, and inasmuch as patient was not suffering much, he was advised to continue poultice another day. He had taken two pills the night before, at his own suggestion, and had reported them this morning. These had not yet operated.

On the 9th day (Aug. 7), there appeared upon his back, at some distance from the focus of swelling, two black spots about half an inch in diameter. Over the swelling the skin had become brawny, and a number of yellowish pimples appeared, just as in cases of carbuncle. He was ordered to continue treatment, and to take an abundance of nourishment and egg-nog. Pulse about 100 per minute.

10th day. The black spots had extended so as to include the entire lumbar region on both sides. But little pain. Retention of urine continued. Carbolic acid ointment (very weak) was spread upon a cloth and applied to the back, to prevent his clothes from sticking.

11th day. A space ten by twelve inches was denuded of cuticle; a slough about four by five inches was forming in the true skin on the right side; pulse 145; extremities cold; cold, clammy sweat. Diarrhoea set in during the night. Died at 2 o'clock P. M.

This patient was somewhat worn down by hard work and dyspepsia. His case, from the start, was marked by very slight delirium up to the day he died, when it became a decided feature. Both the cases were singular, in the fact that but little pain was complained of.

At the present writing, from notes made at the time, Case 1 has fully recovered, and before closing the paper will add another case, which is yet under observation.

CASE 3.—S. S., farmer, age about 65, consults me in regard to his thumb, which has been swollen some two or three weeks, and supposing it to be of the nature of a

felon, has been poulticing it, and a day or two previous has had it partly opened.

Being very busy, I kept no notes of the case, nor record of visits, although these, for the greater part of three weeks, were made twice and three times a day.

Upon my first visit, the appearances were so much those of a phlegmonous inflammation I carried a scalpel down to the first phalanx of the thumb, making an incision half or three-quarters of an inch in length. Only a little unhealthy pus was evacuated, and this apparently from just beneath the true skin. This incision, during the next three or four days, was carried through the true skin, across to and down the index finger to the junction of the second and third phalanx. The inflammation extended to the second and third fingers, the palm of the hand, and up the arm. The patient being feeble, he took constantly iron and quinine, and had advised for him egg-nog, but took none of this till the second week of my attendance. Incisions were made in various parts of the hand and fingers, being carried down to the bone in places, but the entire suppurative action seemed to be located in the subcutaneous connective tissue and skin. During the first week, gangrene set in, in the end of the thumb and index finger. Solutions of carbolic acid, bromine and permanganate of potash, were constantly used. To the washing out of the deeper diseased parts I attended myself. The connective tissue in the arm suppurated to within three or four inches of the elbow, mainly upon the palmar surface of the arm. Lengthy incisions gave exit to no more pus than shorter ones, through the local pockets. For the last few weeks of the suppurative action, only short incisions were practiced. During the second or third week, the entire fore-finger seemed to be gangrenous, as well as the end of the thumb. Intense pain required the constant use of morphine. About the fourth week the inflammation began to subside in the arm, and finally subsided, to some extent, in the hand and fingers. The sixth week I amputated

the fore-finger through the second phalanx, since which time there has been a steady but very slow subsidence of the inflammation. Some of the gangrenous spots have not yet healed, and are still having applied to them the solution of bromine, but the patient is convalescing, and will shortly be well.

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DEATH FOLLOWING THE ADMINISTRATION OF  
ETHER, AT THE ILLINOIS CHARITABLE EYE AND  
EAR INFIRMARY.

BY E. L. HOLMES, M.D.,

PROFESSOR OF DISEASES OF THE EYE AND EAR, RUSH MEDICAL COLLEGE.

(Read before the Chicago Medical Society, April 3, 1876.)

Mr. M., in the 74th year of his age, came under my care for the extraction of cataract. Unfortunately, there was chronic conjunctivitis in each eye, which foreshadowed a protracted treatment. The patient was exceedingly obese, especially in the abdominal region—had a remarkably large and finely developed head, with a short and very thick neck. The upper and lower limbs were peculiarly deficient in development, apparently from early childhood, for they were relatively small and extremely short; the hands and feet were also uncommonly small. While the body was very nearly normal in length, the limbs were so short that the whole height of the patient was but four feet three inches. His weight was 184 pounds.

The general health had always been quite good, enabling the patient to perform his duties in an important State office, which he had held nearly forty years, till he became blind. The patient had become slightly asthmatic, and was troubled with some cough. Although faint rales in the chest could be heard, the action of the heart and lungs presented no symptom indicative of failing health. I doubt whether the pulse could be called weak. The appetite, digestion and excretory functions were quite normal. There was, however, a ten-

dency to undue perspiration in exercising, or when the temperature of his room was a little elevated.

In the latter part of December, the eyes were in so favorable a condition that I considered it safe to perform a preliminary iridectomy. The patient took no food after breakfast. Squibb's stronger ether, turned upon a large porous towel, folded several times and covered with paper, was given to the patient, while lying on his back with the head slightly elevated. The patient breathed very quietly, till he seemed to be unconscious, when coughing commenced. This was no more violent than is often observed when this anaesthetic is administered. Scarcely any mucus or saliva collected in the throat. Soon after this, the breathing ceased, and the face became remarkably livid, while the pulse continued regular and strong. Pressure on the chest aroused the respiration, when more ether was given and the operation on each eye completed without further unpleasant symptoms. There was no vomiting.

The wounds in the corneal border healed readily, although from a repeated recurrence of slight conjunctivitis I did not consider the eyes to be in a condition fit for the extraction of cataract for about three months.

Meanwhile the general health had continued as good in every respect as it had been. Dr. I. N. Danforth had given the patient simple remedies to relieve a trifling cough and asthma, and to overcome the undue perspiration. The asthma never prevented sleep in the recumbent position. At half past three, on the 27th of March, Squibb's ether was again administered under precisely the same circumstances as at the previous operation. I must confess that nothing in the patient's condition excited the least suspicion, either in Dr. Danforth or myself, that a fatal result could follow. The thought never entered my mind, although I had some solicitude regarding the success of an extraction of cataract in an eye which might be considered predisposed to inflammation. The patient was in a cheerful state of mind, and inhaled the ether quietly till about half a pound had been consumed,

when quite violent coughing commenced. This was soon followed by an extremely livid appearance of the face and then by a cessation of breathing. I placed my finger on the pulse, found it failing in strength and directed my assistant to remove the towel, and others in the room to raise the foot of the bed as high as possible. Meantime I raised the tongue, and with the other hand made very forcible pressure every few seconds on the side of the chest.

Respiration was at once re-established, as also full action of the heart, when I directed the foot of the bed to be let down. The lividity in a great measure disappeared. Even at this moment I did not think of danger, but, without giving more ether, rapidly commenced and completed the section, and, as the iridectomy had already been performed, as rapidly removed the lens. This passed through the wound at once with only the least possible manipulation. The bandage was speedily adjusted. I cannot think two minutes elapsed from the commencement of the section to the final adjustment of the bandage. I made the steps as rapidly as was consistent with care, being not quite certain that the patient had taken ether enough to keep him unconscious sufficiently long for the possible delay in "delivering" the lens, which occasionally happens. My usual method of applying the compressive bandage reduces the time to a minimum, since I place an elastic band around the forehead ready in any emergency to be slipped over the eyes. I am confident, therefore, that all this required less than two minutes, when I observed that the patient did not breathe, that the face was more livid and the pulse very weak.

The same course was pursued as before the operation as regards drawing up the tongue, raising the foot of the bed and inducing artificial respiration, and, in addition, by forcing air into the lungs (?) by the breath. At the end of a minute or more, I could feel no pulse nor hear the heart ; the face had become exceedingly livid.

The efforts I have described, except raising the foot of the bed and forcing the breath into the mouth were continued an hour and a quarter.

There were present my assistant, the matron, the resident pupil, and one of the nurses. Galvanism was not employed. No autopsy was obtained.

In neither case was the towel held so close to the face as to prevent the entrance of sufficient air into the lungs.

It is perhaps due to myself to state, that for nearly fourteen months in 1853-4, I was resident assistant in the Massachusetts General Hospital, at Boston, and administered anaesthetics, under the supervision of the surgeons, in a large number of cases. Subsequently I witnessed the administration of chloroform very frequently, in European hospitals. For about eleven years ending 1867, I used chloroform almost exclusively in hospital and private practice. In several instances in my practice the use of chloroform was followed by the most alarming symptoms; the action of the heart and lungs absolutely ceased, as far as could be observed by auscultation of the chest. In every instance there was sudden and apparently complete syncope. Fortunately no fatal result occurred.

After observing two or three of these cases and witnessing numerous instances in which danger seemed imminent, I made the experiment of placing the patient with head down on an inclined plane of at least 45°. I found without exception, in extreme cases and in cases where there was slight enfeeblement of the pulse with pallor of the face, that this change of position caused immediate fullness of the pulse and flushing of the cheeks. I was led to this step by the appearance of the patients, and by the recollection of seeing one of my early medical instructors seize a child, apparently dead from shock and loss of blood, by the feet and hold it a moment head downward. This brought to my mind the injunction of another teacher (in obstetrics), to raise the foot of the bed as high as possible in cases of dangerous haemorrhage.

I experimented very many times, and soon resolved never to administer chloroform unless the patient was placed on a suitable board, so the position could be easily changed with the least delay.

Although I have long since abandoned the use of chloroform, I am fully convinced that this treatment—by increasing the hydrostatic pressure of the blood at the nervous centres—reduces the dangers from chloroform to a minimum, and at this minimum, chloroform can scarcely be considered as an especially dangerous anaesthetic. I apprehend, physicians in resorting to this method, too often fail to apply it *promptly*, and in such a manner that the whole body is on a very steep inclined plane. These points are of primary consequence as compared to elevating the tongue.

A notice of these observations was published in the transactions of the Illinois State Medical Society for the year 1868. This was copied in a large number of medical journals—as far as I know—without comment regarding originality. It was only till somewhat recently that I learned from Dr. J. Marion Sims in person, and from his published address, that the method had been employed years before by Nélaton.

Ether, as well as chloroform, sometimes causes dangerous cessation of breathing. I believe this, with the secondary effect, lividity, is due to the action of the anaesthetic on the nervous centres of respiration. I had observed during my first experiments that patients in this state placed in the position above described invariably and speedily began to breathe. The elevated column of blood seemed to excite the nerve-centres.

I may add, that I have seen two cases in which the administration of ether was followed, as the patients regained consciousness, by most violent and protracted neuralgia of the left arm.

## TAPPING OVARIAN TUMORS.

By M. B. WRIGHT, M.D.,

LATE PROFESSOR OF OBSTETRICS IN OHIO MEDICAL COLLEGE.

I have derived pleasure and profit from a perusal of Dr. Byford's paper on ovarian cysts. It gives a comprehensive view of the entire subject, and presents very clearly individual sentiments, respecting the utility of operations and their kind. What shall be done with the more solid tumors is a question admitting direct replies. Remove them bodily, or let them alone. The treatment of these tumors by medicines, such as act on the kidneys, intestines and skin, or by counter-irritants, is of doubtful efficacy. My own belief is, that their long continuance impairs the general system, and tends to increase rather than retard the growth of the tumor. A well devised tonic treatment, with the introduction of a cotton ball saturated with tinct. iodine, and the fluid ext. ergot, and glycerine, one part of the former to two parts each of the latter, have given much satisfaction before the tumors had attained any considerable size. But my object at this time is rather to present a case of single cyst, cured seemingly by tapping alone.

S. P., aged 17, single, entered the Cincinnati Hospital Aug. 12, 1874. Family history good; parents, substantial Germans.

Two years ago, she observed a degree of tumefaction in the lower and pubic portion of the abdomen. For a time it was attributed to flatulency, and for this treated. The abdomen increased gradually in size, and without much inconvenience until May, 1874, when, from oppressed breathing, it was deemed best to resort to tapping. A large quantity of fluid was drawn off (quantity not given) to the great relief of the patient. No pain was experienced during the accumulation of fluid. Now and then, however, subsequent to tapping, lancinating pains were felt in the abdomen, and the catamenial function was suspended during two periods.

When the patient entered the hospital, three months after the tapping, the enlarged abdomen measured thirty-five inches. She also complained of pain in the left ovarian region.

August 31. Breathing is somewhat oppressed ; measurement,  $38\frac{1}{4}$  inches ; fluctuation is distinct ; there is dullness on percussion, except in the lumbar regions, where there is distinct resonance. The swelling has a little more prominence in the left than right iliac region. There is an unusual firmness in the left cul de sac of the vagina.

The diagnosis is a unilocular ovarian cyst.

The patient had been advised to enter the hospital, and submit to an operation. The summer heat was unfavorable for an operation as hazardous as that of ovariotomy. Tapping presented three points for favorable consideration : the comfort of the patient, a more accurate diagnosis as to the solid elements of the swelling, and the most judicious treatment. In view of the general condition of the patient, as well as the diagnosis, I felt strongly urged to test the efficacy of tapping, as a prominent means of cure. Accordingly, I drew from the cyst, by means of a bistoury and gum-elastic tube, inserted in the linea alba, twenty-six pints of a denseropy fluid. Before the complete emptying of the cyst, the patient became slightly faint, from which she soon rallied by slight stimulation. A compress and bandage were applied, and the patient ordered to bed. In two or three days she was walking about, and on October 26 she left the hospital.

She was re-admitted April 5, 1875, with a prominent abdomen, although not as large as at the last tapping. Her bowels were inactive, and the kidneys were not secreting well. Her appetite was impaired, and her strength had failed. Under the influence of purgatives, diuretics and tonics, a better state of health was established.

May 28, she was again tapped, with sensible relief.

June 28, she left the hospital, since which time she has increased in flesh and strength, and up to this time, Feb. 10, 1876, there has been no perceptible accumulation of fluid.

This case afforded just ground for discussion. On the one hand it was claimed, that, ultimately, a more radical operation would be demanded, and that while the patient remained in general good health, success might be reasonably anticipated. On the other hand there was before me a young woman of fine physical development, and who was suffering in no way except from her bulk. There was no evidence of a solid tumor. She could be relieved by a simple operation, and this could be performed from time to time without danger. The re-accumulation of fluid was at long intervals. The hope of final success seemed justified. And the question, how long will the patient live? was not pertinent nor pressing. Again, I am in favor of a partial or complete evacuation of the cyst before an attempt is made for its removal by incision.

The following case presents some points of interest as taken from the hospital record :

E. L., widow, aged 42. Has been pregnant seven times, the last six pregnancies terminating prematurely. Attributes her miscarriages to hard work—washing, ironing, etc. Has not been pregnant for fifteen years.

About four years ago, she observed a swelling near and below the umbilicus, which has been gradually increasing. There is difficult breathing in any position, but she cannot sleep in the recumbent posture. The abdomen is of immense size and irregular upon the surface. The diagnosis is, a more or less solid tumor, with many cysts of varying dimensions. Fluctuation, here and there, was observed in the larger cysts near the surface. One was punctured below the umbilicus, and two between the umbilicus and superior spinous process of the ilium, on the right side. The aggregate amount of

fluid drawn, measured two hundred ounces. The fluid in the three sacs differed both in color and consistence.

The next day, June 21, the report was that she had slept soundly in any position, and that she was comparatively at ease.

June 23. The patient is walking about the ward, cheerful and free from pain.

About the first of August she was regularly transferred to the care of my associate and successor, Dr. Tate. Notwithstanding the patient suffered the inconvenience of bulk only, she expressed a strong desire for the removal of the tumor. Accordingly, on a cool day in November, Dr. Tate performed ovariotomy. Extensive and strong adhesions were found, complicating the case, and rendering it almost necessarily fatal.

The operation, deliberately and skillfully performed, was followed by death on the third day. The tumor weighed about twenty-five pounds.

Every operation for the removal of ovarian tumors, whatever may be their character, is attended with hazard. I have witnessed an expert extraction of a single cyst, without adhesions, with a fair state of general health, and with favorable surroundings, which terminated fatally, contrary to all reasonable expectation.

Again, the operator has taken up his knife with fear and trembling, feeling that death was in every incision, and yet the result has been favorable. Hence, the diagnosis of a case and the effects of an operation are vastly different.

Those who are opposed to tapping, carry their prejudices so far as to declare that it renders a radical operation uncertain, if not positively fatal. There has been nothing within my limited experience that justifies any such assumption. I have tapped and seen tapped many cases of single and multiple cysts, with decided benefit, and without injury in a single case. Does inflammation result from tapping, and thus add gravity to the disease and the operation? It is scarcely possible. The punc-

tures, for illustration, in the case above, had nothing to do with the inflammation and adhesions already described. They were free from even a blush of inflammation. It is urged that the sacs refill, and often rapidly. Suppose they do, they are no more unpromising than the original cysts, and if need be, tap again.

Those who have operated most frequently, and are most distinguished for success, not only desire quietude, pure air, and a "preparation" favorable to the healthy performance of the functions, but a bracing temperature as auxiliary to success. Summer heat is prejudicial to all grave operations. Now, suppose a tumor, partly if not wholly cystic, should create discomfort almost beyond endurance, and the season should be unfavorable for an operation, would it not be better to lessen the volume of the tumor by tapping, than to attempt a radical cure? Palliation, if possible, is demanded in every case, curable or incurable.

CINCINNATI, Jan. 25, 1876.

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THE CHICAGO SOCIETY OF PHYSICIANS AND SUR-  
GEONS AND THE GOVERNMENT REPORT ON  
CHOLERA.\*

By I. N. DANFORTH, M.D., and J. N. HYDE, M.D., OF CHICAGO.

We desire to call the attention of the medical profession to the volume entitled, "The Cholera Epidemic of 1875 in the United States," which was recently issued from the Government Press. It was prepared in accordance with an Act of Congress, passed on the 25th of March, 1874, and is, in fact, a compilation of Reports from the Secretaries of the Treasury and the War Departments, transmitted to the Senate and House of Representatives by the President of the United States in a message bearing date January 13, 1875.

\* Published in accordance with the resolution of the Society.

We do not propose to review this work, as that labor has been carefully and conscientiously performed by numerous critics connected with the medical press of our country. We desire merely to comment upon the following statement to be found on the 37th page of the work :

"Through the kindness of Dr. Ben. C. Miller, Sanitary Superintendent of Chicago, we are able to present the results of a series of microscopic examinations which were made at his request by Dr. I. N. Danforth, of Chicago, the autopsies from which the specimens examined were obtained having been made by Dr. Marshall W. Wood, now of the U. S. Army. These reports are possessed of an additional interest from the fact that they are as yet the only published American investigations conducted in the epidemic of 1873."

During the summer of the year named, an epidemic visited a limited district of the city of Chicago lying just beyond its southern limits. It was soon after announced in an open meeting of the Chicago Society of Physicians and Surgeons, that cholera had made its appearance in the neighborhood of 37th and Burnside (now South Dearborn) streets. A resolution was promptly passed, requesting all members practicing in that locality, to report their experience in full. The response was equally prompt and full of interest. Minute details were given, respecting the origin and extension of the disease, together with the history of several typical cases. Dr. W. M. Boyd at one meeting exhibited a map indicating not only the houses and streets of the infected locality, but also showing the line traced by the advance of the epidemic. These reports awakened great interest among the members of the Society, who attended all its meetings in large numbers. One special meeting was called and held for the sole purpose of discussing the questions relative to the epidemic malady. The need of complete investigation and elaborate reports, was appreciated by all. On the 18th day of August, 1873, two committees were,

by unanimous resolution, appointed for this purpose. They were constituted as follows: "On the History, Nature and Contagiousness of the Disorder, Dr. Thomas Bevan, chairman, Drs. John Bartlett, C. J. Simons, I. N. Danforth and Lester Curtis. On Prophylaxis and Treatment, Dr. J. H. Etheridge, chairman, Drs. H. P. Merriman, W. M. Boyd and F. H. Davis."\*

Dr. Hyde was then secretary of the Society, and was naturally interested in forwarding, as far as possible, the work which had thus been inaugurated. On the evening of Aug. 27, a hasty and imperfect post-mortem examination had been made by a medical student, of the body of a patient, dead of cholera in the district of the city to which reference has been made. From this young and inexperienced student, Dr. M. W. Wood secured four specimens, removed from the body, and the merest scrap of information relative to the ante-mortem history of the case. These few facts and specimens were brought to Dr. Hyde as secretary of the Society, and by him transmitted to Dr. I. N. Danforth, who, according to previous arrangement, had been charged with the report on the pathology of the disease. Dr. Danforth erroneously concluded that Dr. Wood had conducted the autopsy referred to, and felt, very properly, that the city of Chicago should not permit its public institutions to be administered in so lax a manner. As the patient had died in a Cholera Hospital, he naturally supposed that the examination and report had been made by an officer of that hospital. In his report, therefore, Dr. Danforth characterized the clinical history of this case as "provokingly meagre and deficient, especially when it is taken into consideration, that the patient died in a public hospital, subject to the disciplinary regulations thereof."

We refer to these facts in order to save our friend, Dr. M. W. Wood, from the imputation of having made this defective and slovenly post-mortem examination, as it

\* This is a transcript from the Records of the Chicago Society of Physicians and Surgeons.

would appear from the Government Report. Dr. M. W. Wood is known to us as a careful and conscientious surgeon, who is to-day an ornament to the medical staff of the army as he is to the membership of the medical organization that had undertaken the investigations in question.

Conscious of the need of further material, and aware of the meagre character of the results afforded by this first examination, Dr. Hyde offered to conduct a second necropsy, should opportunity for such be offered. Accordingly, at 10 A. M., of Sept. 9, 1873, Dr. Hyde, at the request and in the presence of special sanitary inspector Dr. Chas. J. Simons and Dr. M. W. Wood, made a section of the body of Joseph Schere in the Cholera Hospital. At this time every viscus of the cranial, thoracic and abdominal cavities was carefully inspected and dissected, and a specimen of each forwarded to Dr. Danforth with eleven cholera stools, separately bottled and consecutively numbered, together with notes of the gross appearances of the organs and as much of an ante-mortem history as could be obtained, not only at the hospital but at the other places visited by the patient before death.

It is made to appear in the Government Report that Dr. Hyde merely served as a clinical clerk on this occasion, though the record of the autopsy is given in his language. Neither Dr. Wood nor Dr. Simons ever claimed to have made this autopsy. The labor incidental to its performance occupied the entire forenoon, and Dr. Hyde was for two days afterward prostrated by cholera-like discharges, which speedily yielded to proper treatment.

The question considered above, however, is of much less importance than that which follows, viz.: "*Can the Board of Health of Chicago justly claim that these examinations were conducted under their direction, and thus appropriate the results to which they led?*" This

is the question which has led us to present the facts in the case to the notice of the profession.

The following extracts copied from newspaper clippings of daily journals of Chicago, published during the prevalence of the epidemic, may serve to indicate the part taken by the Board of Health at that time.

The first—a secular report of an open meeting of the Society of Physicians and Surgeons—reads as follows: “Dr. Bartlett thought the disease was *Cholera Asiatica* and nothing else. He wanted to know what the Board of Health were doing and what they were paid for, if they permitted such a state of affairs as that spoken of by Drs. Boyd and Jackson. The condition of many parts of the city was outrageous.”

The “state of affairs” to which Dr. Bartlett had referred, was that which had been graphically described by medical men practicing in the infected locality, they having testified before the Society, that, in some instances, cholera dejections, neither deodorized nor disinfected, had been thrown out upon the streets, and there suffered to remain, the fruitful parents of a progeny of disease-germs. At another time, it had been stated that feather beds, upon which patients of German nationality had evacuated the contents of their bowels and subsequently died, had been, without any interference, transported from one locality to another on the removal of the survivors of the family from the infected to a more salubrious district.

Whether the Board of Health were finally aroused by the appearance of these startling statements in the public press of the city, we do not presume to decide. But it was no secret, at the time, that the Board desired medical men to report patients who were the victims of the epidemic disease, as dead of *cholera morbus*. It is somewhat doubtful whether they believed cholera to have actually affected the city. Here is a second extract, illustrative of this point:

“Dr. A. R. Jackson said it was an important point to

determine whether these cases should be acknowledged as cholera, or whether, *as demanded by the Board of Health*, they should continue to call it cholera morbus."

These words were taken down by a reporter of the daily press then present.

On the appearance of these details in the public journals, one daily newspaper, which chanced not to be represented at this particular meeting, soon after published an article headed "No Asiatic Scourge!!" From it the following extract is appended :

"The sanitary superintendent w first sought, but found to be housed on account of a slight indisposition. His secretary who keeps the records and compiles the statistics of the Board of Health, said that no cholera cases had been reported from any part of the city, and that there had been no deaths from the disease."

Subjoined was a tabulated statement, evidently taken from the records of the Board, going to show that the health of the city was unprecedently good, and that the rate of mortality was even less than during the same season of the preceding year. If the figures did not lie, Chicago decidedly was innocent of cholera.

Very different was the sentiment entertained by a large portion of the members of the Society of Physicians and Surgeons, some of whom were practicing in the infected locality, and many of whom visited it for the purpose of confirming the facts here reported. The view, however, held by Dr. Wood at this time was essentially different from that of the others, and is well set forth in his able and interesting letter published in the Government Report.

After the epidemic had completely subsided, the sanitary superintendent, presumably for the first time, learned of the investigations pursued by the Society. He then communicated with Dr. Hyde, requesting to be allowed the use of the papers prepared on the subject for a report which he was about to make to the National Health Association in New York.

His request was cheerfully complied with. Dr. Hyde at once called upon Dr. Danforth, and, as the secretary of the Society, requested the latter to furnish the required material. Subsequently the statement was made to Dr. Danforth, by one high in authority, that the Board of Health were parties to the investigation and thus entitled to make use of its results. Dr. Danforth, thus assured, permitted his manuscript to go out of his hands.

We presume that it was incorporated into the report made by the sanitary superintendent to the Health Association in New York ; and hope that in the latter, credit was given where credit was due.

In his report, however, to the Board of Health of the city of Chicago, dated March 31, 1874, and published in book form during the same year, these reports are incorporated in full, and prefaced with the following statement :

“A microscopic examination of Cases II and III was made by Dr. Danforth *at my request*, who has kindly furnished notes and drawings of the examination.”

On the evening of February 9, 1874, Dr. Danforth in due form presented to the Chicago Society of Physicians and Surgeons his written report of the sub-committee on the pathology of the epidemic as it had occurred here. His paper was, at his request, read by Dr. Bridge, and he in the meantime, exhibited his microscopical sections of the intestinal membrane, etc., illuminated by the oxy-hydrogen light and explained their various appearances as they passed beneath the objectives. The meeting was very largely attended not only by members of the Society, but also by invited guests who had assembled in consequence of the unusual interest of the proceedings. After the reading and exhibition of the specimens were concluded, the report was duly accepted, and Dr. Danforth received, by resolution, the unanimous thanks of the Society.

The introductory pages of this report are subjoined,

not only as showing the circumstances under which it was prepared, but also as determining what was suppressed or elided from the manuscript which had been previously loaned to the officials of the Board of Health and by them published in a fragmentary manner.

"**REPORT ON THE PATHOLOGICAL ANATOMY AND HISTOLOGY OF CHOLERA.**

By *I. N. Danforth, M.D.*, Lecturer on Pathology in Rush Medical College. Read before the Chicago Society of Physicians and Surgeons, Feb. 9, 1874.

Early in the summer of 1873, epidemic cholera made its appearance in the city of New Orleans, and, in spite of vigorous sanitary measures, it rapidly spread in all directions. It swept northward through the Mississippi valley, capturing and conquering city after city, and hamlet after hamlet, in defiance of the fact that civic authorities had entrenched themselves behind the most approved measures of prophylaxis, and in direct violation of its own time-honored law of migration. In the month of August it reached Chicago, and became "endemic" in the so-called Bridgeport district. Probably in no part of Chicago are the sanitary conditions so desperately bad as in the section above mentioned. As the duty of reporting at length thereupon has been assigned to another member of the committee, I may dismiss the subject by remarking that the habitual drinking of surface water for want of hydrant water, the enforced dependence upon surface drainage in default of underground sewerage, and the total absence of pavements upon the streets, form the main elements of a problem so easy of solution that it is scarcely a problem at all.

On the 18th of August, 1873, the "Chicago Society of Physicians and Surgeons" appointed a committee, whereof Dr. Thomas Bevan was chairman, to investigate the "history and nature of the disease now prevailing in the south-west district of the city, with especial reference to the question of contagion." The committee consisted of Drs. Bevan, Bartlett, Danforth, Simons and Curtis; a

division of labor was subsequently made, and to the writer was assigned the intrinsic pathology and microscopy of the disease in question. The infected districts was so far from my own residence that it was impossible for me to visit it for the purpose of making autopsies. I was therefore reduced to the necessity of taking what morbid specimens I could get, and make my report thereupon. Through the kindness of Dr. James Nevins Hyde, I have been furnished with the histories of two cases, with specimens of evacuations (both ante- and post-mortem), and several specimens of intestine and other organs. In the following report, I have entered upon no speculations, but have endeavored to faithfully and somewhat minutely record the gross and microscopic appearances, with the hope of adding somewhat to our knowledge, particularly in the domain of pathological histology."

With reference to Case II, it is said :

"Dr. Hyde \* \* \* furnished me the clinical history so far as he could obtain it, and very complete notes of a very complete and workmanlike post-mortem examination made by himself. I cannot do better than insert Dr. Hyde's account of the case at length, which is as follows :"

When Dr. Ely McClellan of the U. S. Army visited Chicago during the period in which he was engaged in the compilation of his part of the "Report on Cholera," issued by the Government, he was a guest of the sanitary superintendent. At the request of the requisite number of the members of the Chicago Society of Physicians and Surgeons, Dr. Hyde, who was then also the secretary of the Society, called the special meeting at which Dr. McClellan presented his highly interesting sketch of the progress of the disease throughout the State of Kentucky. This meeting was also largely attended, and the speaker took occasion to pay a deserved compliment to the Society by stating that he had collected no reports

which equaled, in interest and value, those obtained from the investigations conducted under its auspices.

Our purpose is now evident. It is to call the attention of the profession to the fact that the part taken by the Society of Physicians and Surgeons is coolly and completely ignored in a volume of 1025 pages published under the auspices of the Government and in accordance with a joint resolution of both Houses of Congress. Or, rather, not being ignored, the valuable portion of its report is as coolly and completely appropriated and credited to the direction of the Chicago Board of Health.

If any deem that this subject is too trifling to require the detailed explanation and correction we have here endeavored to make, we beg leave to recall to such the comment of the "Report" itself, as published by the Government, upon the researches in question, which are pronounced to be "*possessed of an additional interest from the fact that they are as yet the only published American investigations conducted in the Epidemic of 1873.*"

We desire to be understood as charging no one with a breach of good faith, common honesty or professional honor. We desire, in fact, to make no charges whatever. We simply claim to set forth the facts in the case which are briefly these: 1st, That the Board of Health of Chicago had not in any way the slightest connection with the work of inaugurating or prosecuting these researches; and, 2nd, That the latter were undertaken under, and solely under, the auspices and direction of the Chicago Society of Physicians and Surgeons by the instrumentality of its duly appointed committees. To it, therefore, and to no other body, belongs the honor, if any there be, of the work accomplished. Had not these committees been appointed, it may well be doubted whether the investigations would have ever been set on foot; certainly the work performed respectively by the authors of this statement was not undertaken as private individuals, but as members of the Society. The specimens examined

were furnished to Dr. Danforth with that specific understanding, and were examined and reported upon accordingly.

One other correction remains to be made. The formula for the prophylaxis of cholera which was successfully used in the infected district and which is published in the Government Report, was furnished by Dr. Thomas Bevan, and formed part of the report of the committee on Prophylaxis and Treatment, which was also made in due form to the Society of Physicians and Surgeons.

We have thus presented the statement given above, in a desire to do impartial justice to all concerned, and to make a correct historical record of the facts in the case.

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### Editorial.

It will hardly be necessary to introduce the subject matter of the following letters with anything more than a statement of the facts connected with the manner of our possession of them.

Early in March, 1876, the janitor of the Chicago Medical College received a note from the Dean of the Kentucky School of Medicine, requesting him to send the names of a number of the students of the former institution to him.

The janitor complied, and being of an inquiring turn of mind wrote and mailed the following letter to the Dean of the Kentucky School of Medicine. We mark it

(No. 1.)

CHICAGO, March 5, 1876.

Dear Sir—I have attended one year in the Chicago Medical College, and according to the rules of this institution I shall have to spend two more years before I can graduate. Now I want to get through in shorter time in your college; will you then oblige me by stating so, and send me your annual announcement. Respectfully yours,

P. NILSON, 785 Wabash Ave.

To this a letter, of which the following is an exact copy, came as an answer:

(No. 2.)

LOUISVILLE, March 9, 1876.

Mr. P. NILSON: *Dear Sir*—I am just in receipt of your letter of the 5th inst. As you have attended one course of lectures, you would be allowed to come forward for graduation in this school after attending one more course. You can come on here now and join the present class and come forward in June of this year for graduation. I send you a catalogue.

Yours very truly,

E. S. GAILLARD.

Letters Nos. 3 and 4 were handed to us by Prof. Nelson of the Chicago Medical College, who vouches for their genuineness.

(No. 3.)

CHICAGO, March 21, 1876.

*To the Dean of the Louisville Medical College, Louisville, Ky.:*

Sir—I am desirous of attending college this summer. I address you in relation thereto.

I am a man of 25 years; my early education I obtained in Indiana and my classics in Rockford, Illinois. I began the study of medicine in December, 1874. I have attended a course of summer lectures of three months, and a winter course of six months, both courses being taken in Chicago Medical College.

I have creditably passed the Junior examinations and completed three dissections of the human body.

Now will you admit me as a student of your college and at the same time allow me to come up as a candidate for graduation, and graduate at the end of this present session; providing I pass the required examinations and furnish certificate of moral character.

As I have been detained for examination in the Chicago Medical College which closes this 21st inst., your immediate answer will oblige

Yours truly, M. M. ROWLEY.

P. S. Please send me catalogue to 45 South Clark Street, Chicago.

Letter No. 4 came in answer to the above.

MR. M. M. ROWLEY:

LOUISVILLE, Ky., March 24, 1876.

*Dear Sir*—Your letter of the 21st inst. has just been received. You can enter the present session of this college and come forward for graduation with the class in June; I would advise you, however, to come on with the least possible delay, as the course was begun on the first of this month. I send you a catalogue by this mail.

Yours very truly, E. S. GAILLARD.

Commentary upon the above letters is entirely unnecessary. They are plain and to the point.

## Correspondence.

IRVING, N. Y., March 6, 1876.

*To Wm. H. Byford, M.D.:*

SIR—The case of Milton Brooks which I present you for publication is one which has awakened great interest among the medical men of Chautauqua county, and I doubt not will interest the readers of your Journal in the western part of our country. Perhaps Dr. Rogers will report it in an Eastern journal, but I think he has not obtained a full and perfect history of the case.

A very remarkable case of what has been called extreme costiveness by the physicians who have attended him at various times during a long period of sickness and suffering, has recently come under my observation. Believing it to be a case which will be of deep interest to the medical profession, I propose to give a brief history of it for publication in your Journal.

Milton Brooks, now deceased, had been the subject of a distressing complaint from the age of two years up to his death, which took place at the age of about 26 years. I have obtained the following statement from his parents. While an infant, nearly two years of age, he suffered from diarrhoea which became chronic and defied medical treatment for several months, but yielded at last, and was immediately followed by constipation, which condition of the bowels continued up to his death, but varied in their time of movement, the evacuations varying in time from two weeks, or about that, up to eight months and sixteen days. It was quite common for three, four and five months to intervene between evacuations.

During this great length of time this condition of his bowels continued without much mitigation, if any, from medical treatment, and that was often resorted to. He was treated by several physicians during his illness. Dr. Harrison, of this county, treated him mostly while

in youth. Subsequently, Dr. Strong, of Westfield, Dr. Rogers, of Dunkirk, Dr. Bishop, of Silver Creek, and during the last three months of his life, I attended him. While he was under my care, I obtained from him a more minute description of his symptoms from the time he was old enough to understand and remember particulars about his sickness and suffering. I learned from him, as well as from his parents, that he suffered extremely every time he had evacuations of feces, often several hours, notwithstanding the evacuations were thin.

Generally, after his evacuations, pain gradually passed off and he would feel quite comfortable, eat quite hearty and do some light work, until he was again distended from the accumulation of feces in the colon. The accumulation being gradual, his body seemed to accommodate itself to the condition, but he was obliged to eat less as the distention increased, but at last the pressure on the stomach appeared to interfere with the functions of digestion, then his food would enter into fermentation, gas would generate rapidly, severe distress would commence, eructation would follow, and sometimes vomiting. The instincts of nature would be awakened and he would press and knead his bowels. In this way he would procure evacuations, and I concluded from his own account and my own observations during my attendance of him, that he never had a natural evacuation by the unaided efforts of nature, but always from gas, pressure and kneading of the bowels. The evacuations were enormous when the intervals without a passage were extended several months.

After the time that he went eight and a half months, he was weighed before the evacuation, and a few days after, and his weight was forty pounds less. This, to strangers to the case, would appear incredible, but we who know the character of the young man and that of the parents do not doubt the statement. Notwithstanding this abnormal condition through his whole life from infancy, his system was well nourished, and developed into an

average-sized man. The only time he was comfortable was from the time of evacuations until the pressure from accumulation upon his stomach, his lungs and his heart took place; then he suffered continually until he had evacuations. After his growth was completed he became quite fleshy; quite a large accumulation of adipose had taken place about the intestines and under the skin. The great pressure from the accumulations produced considerable deformity of his body or disproportion, as the measurements at different times have shown.

He was never able to do any hard work. He could not run, or get around in a hurried manner like young men in general. He was always moderate in his movements. He was pale and exsanguine. His intellectual faculties were well developed, and I should judge he had a fair common school education.

This case being decidedly a remarkable one it attracted the attention of several medical men of this county who had the privilege of investigating it. He has several times been brought before the medical society of this county at the annual meeting, for examination. Dr. Rogers, of Dunkirk, in this county, reported the case to the members of the faculty at the annual meeting of the American Medical Association or a State Association, (I am not positive which), I think nearly four years since, as it then existed.

Dr. Strong, of Westfield, reported the case in the *Philadelphia Medical Journal* in October, 1874, as he found it at that time. His report is as follows:

"Milton Brooks, residing in Sheridan, Chautauqua Co., New York; age, 24; height, 5 feet, 10 inches; unloaded weight, 125 pounds; skin pale, and has a waxy look, tongue clean and pale; has been habitually constipated from childhood. The first medical history of him which I have obtained is by Dr. Geo. S. Harrison, of Sinclairville, who attended Brooks when two years old for costiveness. His habit then was to go about two weeks without fecal evacuations.

Several years later he attended him for diphtheria, and the time was then extended to six weeks. Dr. H. has occasionally seen him and watched the case up to this time, and says the disease has been gradually increasing. For the last six years he has been under my observation and has several times been before our medical association where careful measurements and examinations have been made. Most of the medical men of this county know more or less of the case. In May, 1872, I took the following measurements of him naked :

One girth above the nipple,  $34\frac{1}{2}$  inches ; one girth at umbilicus, 36 inches ; one girth 2 in. above umbilicus, 37 inches ; one girth 3 in. above umbilicus, 39 inches ; one girth 4 in. above umbilicus,  $39\frac{1}{2}$  inches ; one girth 6 in. above umbilicus, 39 inches ; one girth at lower end of sternum, 38 inches. Apex beat of heart one inch above nipple and one and a half inside.

March, 1874, I took the following notes :

Four weeks after he had a partial evacuation, and four months before he had a complete one. Girth at umbilicus,  $37\frac{1}{2}$  inches ; girth at 4 in. above umbilicus,  $38\frac{1}{2}$  inches ; girth at 6 in. above umbilicus,  $38\frac{1}{2}$  inches ; girth at epigastrium, 38 inches ; girth at nipple,  $36\frac{1}{2}$  inches.

Dr. Bishop, of Silver Creek, who is now B.'s adviser, wrote me, May 7, 1874 : His bowels have moved a little several times since you saw him at my house, March 14. Once or twice a year he has had an attack of vomiting attended with violent pain in the stomach and bowels, since I have been his medical adviser.

In 1872 he had such an attack which was controlled by hypodermic injections of morphine, and again in 1873 the same occurred and bowels were completely evacuated. The process of defecation lasts from two to four days, at which time he is sick and becomes much exhausted ; the dejections look like brown paper chewed.

There is free escape of gas per anum. The weight of fecal matter at one dejection was approximately obtained. He was accidentally weighed just before the movement

and again as soon after as he could get to the scales. The difference was forty pounds. The longest interval between any fecal discharges occurred four years since, and was eight months and sixteen days. His abdomen when loaded is hard, the colon immensely distended and easily traceable.

He is a laboring man, does light work on a farm in a moderate way. He has been under the care of many physicians of all kinds, both intelligent and otherwise, and every imaginable treatment, followed by no permanent benefit.

P. S. Since writing the above report, Dr. Bishop writes me that he has pursued the course of treatment agreed upon by us last spring, and has given to B. the elixir of cinchona, iron and strychnine, with occasional small doses of calomel, the result of which has been evacuations at shorter intervals, so that his body was diminished somewhat. From this date given by Bishop, 1874, down to the present time (I do not mean the date of this report) but the time he first called me to treat him, there has been no material change in his symptoms."

The treatment agreed upon by Doctors Strong and Bishop only improved his condition for a few months. Mr. Brooks called on me some two months previous to his death. He first complained of pain in his back, in the region of the kidneys, of loss of appetite and occasional nausea. His tongue was covered with a yellow fur, and his urine was scanty and had a dark, dirty appearance, without much, if any, sediment. I gave a few doses of hyd. cum creta, with Dover's powders and nitre and buchu; he appeared languid, and was inclined to keep the bed a part of the time, through the day. Some eight or ten days later I was called again; found him in great pain in the bowels, and in the left side in the region of the heart; his whole body appeared full and hard; he occasionally vomited. I immediately gave morphine hypodermically, which gave prompt relief, but the anodyne treatment had to be continued for about two days, during

which time his bowels were well evacuated. In a few days he was up and about as usual. In about two weeks he had another similar attack and was relieved by the same treatment, but during this time his tongue and urine gave evidence of deranged secretions ; in about ten days he began to suffer with severe pain in his head ; it came on in the morning and passed off at evening, and was attended with increased circulation and heat ; his thirst was extreme ; his pulse ran from 110 to 120. I gave him the treatment that I judged his disease indicated. In about a week he recovered, a good appetite followed, and he gained strength quite rapidly, eating largely of hearty food, which he generally craved. About ten days subsequent to this attack, a severe pain in the stomach commenced, followed by great distention of his entire body, with copious evacuations. The pain soon reached his heart. I gave him an hypodermic injection of acetate morphia, followed by large doses of tincture of opium, which gave him considerable relief for about twelve hours, but the evacuations continued.

Pain returned, with greater severity about the heart and lungs, his respiration soon become labored, got no relief from anodynes, and in about forty-eight hours from this attack death came to his relief.

This attack was quite similar to those which he had while under my care every time he had evacuation from the bowels, only much severer, and he sank under the exhausting effect of the pain. He called these attacks diarrhoea. From the knowledge I obtained from my own observation and from Mr. Brooks, I came to the conclusion that he never had fecal evacuations except from accumulations of gas, generated in the stomach.

This brings us to the post-mortem examination which was had the day after his death, (January 22, 1876). Called Dr. Strong, of Westfield, Dr. Rogers, of Dunkirk, and Dr. Thompson, of Angola. The first part examined was the colon. That which first presented, was what appeared to be the ascending transverse and descending

colon. It presented nearly a smooth surface, with but slight, if any, evidence of the longitudinal and circular bands that characterize it in its normal state. On examining it minutely, it was found to extend into the thorax at least four inches above its natural position, crowding the heart and lungs up before it to a transverse line one inch above the nipples; its length was six feet and three inches; its circumference was, in an undistended state, thirteen inches. It was not quite uniform in size, being the largest near its termination in the rectum. It diminished rapidly after passing over the prominence of the sacrum. About three inches below, the rectum was found contracted down to about one inch in diameter where the coats appeared thicker and more muscular. About six quarts of fecal matter were retained. The liver was  $5\frac{1}{2}$  inches thick and nearly double the natural size; the spleen was considerably enlarged; heart small; stomach natural; kidneys small; lungs greatly compressed.

What appears the most remarkable in this case is the fact, that such an organic change should take place so suddenly in a young child as to oppose successfully the natural efforts of nature, and as he approached manhood the resistance increased until most of the internal organs were displaced or otherwise interfered with, and his entire body or thorax and abdomen permanently enlarged.

This case shows another fact that is remarkable. This condition was tolerated twenty-four years, was attended with great suffering, got no benefit from treatment, and still his system was fully developed. Was this hypertrophy? was it paralysis? was it the result of inflammation, and could he have been relieved had the case been understood?

P. S. On looking over what I have written, I discovered I had overlooked an important part of the description of the post-mortem examination. Drs. Rogers and Strong did the work, while I took notes of the exami-

nation. When they had examined the colon and the liver, spleen, stomach and the situation of the heart and lungs, they appeared to be satisfied that they had discovered enough to account for the symptoms in the case. I suggested to them that I believed the cause of the obstruction was in the rectum which had not been disturbed, but the colon they had removed, which at the time contained  $1\frac{1}{2}$  gallons of thin feces. They did not heed my suggestion and said to the family that the examination was satisfactory, they had found all that was desirable. The second day after the body was interred, Dr. Rogers obtained leave of the parents to disinter the corpse and make a further examination. The rectum was then removed, which on examination was believed to unfold the mystery. It was apparently contracted when compared with the colon, but this was only apparent when its organic change showed that its muscular coat was greatly thickened. I should think its thickness was at least three-sixteenths of an inch, and in fact the whole rectum appeared thickened or hypertrophied and unyielding. A ball of hard fecal matter was found in the rectum about one inch in diameter. I have learned from the patient and his parents that his evacuations were always thin and without hardened feces preceding it—unlike all other cases.

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CINCINNATI, March 13, 1876.

MY DEAR DOCTOR:

It seems proper that I should communicate to you some facts respecting the case of single cyst, about which I wrote you some time ago. I have just seen the patient, whose appearance and feelings are those of vigorous health. I was curious to know if there had been any new deposit of cystic fluid. Its presence is not very decided, but I am satisfied that refilling has commenced. In addition, I have detected an elongated and hardened tumor in the left ovarian region—a complication not before apparent.

It is now more than ten months since the last tapping, during which time the patient has not had a day of ill health, nor is there at this time any inconvenience from the presence of tumor or cyst.

The solidity of a part of the morbid growth has changed the aspect of the disease so far as relates to the cure. The long intervals between the emptying of the cyst by tapping, and the general good health of the patient, justified the belief that a formidable operation might not become necessary. The future is somewhat darkened, and in view of this fact, the practical question presenting itself is, what plan of treatment is best calculated to secure comfort and safety?

On one point my friends of the knife differ in opinion. One advocates an operation before the morbid growth has attained any considerable size, and before the general health has become impaired. Another urges postponement until the entire system becomes more or less involved in the mischief.

The former view has the stamp of plausibility, and yet, cases of the most encouraging character, in the hands of skillful operators, have terminated fatally. Others, again, in which there was every evidence of failing health, the operation requiring extensive tearing and cutting, have survived the shock. We are then without sufficient data upon which to form a positive prognosis.

Is it not the wiser plan, in cases of single or even double cyst, to evacuate the fluid by tapping rather than run the certain hazard of ovariotomy? The patient to whom I have more special reference is in good general health, and will probably remain so until the cyst enlarges, so as to produce mechanical inconvenience. An evacuation of the fluid will be followed by a return of good feeling. Thus may the life and usefulness of the patient be prolonged many years. Such are my inducements for opposing the formidable operation of removal of tumor and cyst.

Truly, M. B. WRIGHT.

DR. W. H. BYFORD, Editor, etc.

## Reports of Societies.

### CHICAGO SOCIETY OF PHYSICIANS AND SURGEONS.

*Regular Meeting, Jan. 10, 1876.*

(Reported by EDW. WARREN SAWYER, M.D.)

Dr. Walter Hay was elected to the chair *pro tempore*.

Dr. Lenneker presented to the Society a paper on the surgical treatment of primary retro-flexion of the uterus. The first part of the paper was devoted to the clinical history and general consideration of the subject. The essayist then detailed an original operation for the relief of this displacement. An incision, some two lines in depth, is made the entire length of the internal surface of the anterior uterine wall, along the median line; the external os uteri is cut through on each side with a pair of scissors, and the internal os incised to the depth of two lines upon each side. The edges of the incisions are kept open for a time, and the uterine cavity washed out with pure carbolic acid dissolved in alcohol. Three days after the operation the uterus is righted, and held in place by a modified Noeggerath pessary.

The incisions into the internal surface of the uterus are made with a series of three knives, devised by the author; each knife is a blade projecting from a flexible sound-like staff. The knife intended for the anterior incision is upon the convexity of the sound; while the blades are upon the sides of the sound in the knives intended for the lateral incisions.

The essayist has already done the operation in some twenty instances, and claims success in every instance. Moreover, he has never seen harm follow the procedure. The paper was well illustrated with drawings of instruments, position of patient, etc.

Dr. Sawyer read the notes of a case which had recently occurred in his practice: A complete placenta prævia,

in a woman laboring under transitory Bright's disease ; subsequent pelvic cellulitis, puerperal mania, and death on the sixteenth day ; still-born foetus, weighing thirteen pounds.

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## CHICAGO SOCIETY OF PHYSICIANS AND SURGEONS.

*Regular Meeting, Feb. 14, 1876.*

(Reported by EDW. WARREN SAWYER, M.D.)

President, Dr. Bevan, in the chair.

Dr. Chas. E. Davis reported two cases of congenital syphilis, as follows :

MR. PRESIDENT AND GENTLEMEN :

I desire to call your attention briefly to two cases of syphilis, one congenital and the other acquired, which are interesting, not only because they illustrate the remarkable tenacity of the disease in an infected constitution, but also because they exemplify a marked tendency to repair when the morbid agency is removed.

On the 19th of November, 1875, Mrs. G—— brought her child to me, a male infant four months old, having two large and scaly ulcers upon its face, one upon the forehead, the other covering the lower third of the nose, involving both nostrils and well nigh occluding them. Another large ulcer existed upon the left parietal eminence. With one exception, all the finger and toe nails had sloughed off, the matrix in several cases being the seat of dirty, greyish ulcers, and the extremity of each digit being clubbed. The skin was of a dull, coppery color, the eyes watery and of a dull, leaden hue. There were small blisters on the soles of the feet and also on the lips.

The superficial veins of the head were much enlarged, varicose and filled with dark blood, which presented a remarkable contrast with the dry and hairless scalp. The cervical and axillary glands were slightly enlarged, and the fauces congested but apparently not ulcerated.

On various parts of the body were dark patches which the mother said were the sites of former ulcers similar to those on the face.

The child had been born prematurely, and at birth was puny, cross and feeble. In 24 hours it had become covered with scarlet patches.

The mother seemed ignorant of the nature of the disease affecting her infant, and, in answer to my questions, affirmed that she had not suffered from any eruption, swollen glands or other evidences of disease for years. She admitted, however, that soon after her marriage, three years before, she had had some "soreness of the groin," for which she had received some medicine from her husband, but that she had since remained perfectly well. She had had two abortions, one at 7 months and one at 6 months, the causes of which she did not know. Neither foetus had been seen by her.

Her husband, whom I had an opportunity of examining, was a robust and healthy looking man. He admitted that he had suffered from syphilis seven years before, for which he had been at once treated, and from which he had not since suffered.

The child was placed upon a careful hygienic regimen, Nov. 19, 1875, and the following alterative diuretic in half-teaspoonful doses, three times daily, was administered in sweetened water: B. Potass. bromid. 3*i*; Syr. Stillingiae Co. 3*ij*; Spts. nitr. dulc. 3*ss*; Aq. fluv. ad 3*iv*. M.

After the first day, I ordered one-eighth of a grain of calomel in one grain and one-eighth of sugar of milk, to be given at noon in place of the diuretic.

Nov. 21. The color of the skin somewhat improved. The urine yellow, profuse and offensive. Two powders daily, and one dose of the diuretic.

Nov. 23. Marked improvement in the color and condition of the ulcers; slight feverishness, restlessness and parched lips. Medicine discontinued for two doses.

Dec. 1. The ulcers quite healed; the skin clean; the

eyes bright; all signs of proper nutrition returning. No further unpleasant effects from the medicine, which was ordered to be continued unless some disagreeable effect was produced, and then omitted.

Dec. 4. The child was suffering from a severe cold and had not taken medicine for one week.

Three small patches were then visible on the head, which slowly deepened in color. The medicine was then resumed with the improvement which you can notice. The hair which you see on the scalp, appeared three weeks ago.

(The infant was presented to the Society.)

The points of interest in this case, are :

1. That an infant so diseased should survive.
2. That, under any treatment, its feeble organism should be able to repair such extensive lesions in ten days.
3. That toleration of so extended a course of medication should be established in so young an infant.

The second case I report, is that of the nurse of this child, and it illustrates the fact that an infected individual may remain free from external evidences of the disease for months, or until some intercurrent disease arouses it to an activity which seems the more energetic for its period of incubation.

When I first saw Mary McM—, she was a remarkably healthy-looking and robust Irish servant girl, with a clear complexion, of good habits, modest deportment and an unblemished moral reputation. I was called to attend her Nov. 20, 1875, for a severe cold with menstrual suppression, resulting from washing some stone steps while suffering from the periodic discharge. There was some ulceration of the fauces which proved persistent, but which, considering the character of the girl, did not awaken my suspicions. The menstrual flow was not restored. Soon after, Dec. 29, 1875, she came to consult me for a "queer heat" brought out by some warm

baths. I at once recognized the syphilitic nature of this eruption, and elicited the following facts: She had come from Canada during the preceding June, and was sent by a charitable institution to nurse the mother of the infant whose case is detailed above, during her confinement. She was thus engaged during seven weeks, two before and five after that event. She states that her sympathies having been greatly excited by the condition of the puny infant, she had taken it to bed with her, kissed it and soothed it when the mother was incapable of rendering it such services. This was admitted before she was aware of the nature of the malady with which she was afflicted.

This patient was transferred to the Women's and Children's Hospital, Dec. 29, 1875, where she was treated with alteratives and mercurial inunction for eight days with decided benefit, but was then made an out patient in order to make room for other applicants. She was then transferred to the County Hospital where she suffered (Feb. 12, 1876,) with some intercurrent inflammatory disorder of the bowels. Convalescence began on the 27th day of February, 1876. On the 6th of March, 1876, she was able to sit up in bed, and the syphilitic manifestations upon the surface of the skin were rapidly disappearing.

In commenting upon these cases, Dr. Hyde remarked, that it would be interesting to ascertain the exact facts respecting the syphilitic history of the father, the syphilitic infection of the mother, the site of inoculation of the nurse, and the precise sequence of events in the case of the latter. It is an interesting question which is variously answered, whether it is possible for a syphilitic father to beget a syphilitic child without the intervention of the disease in the mother. A syphilitic father when the mother is free from the disease, rarely, if ever, begets a syphilitic child, the popular idea upon this subject being greatly at fault. A child congenitally syphilitic argued a syphilitic mother. Whether the influence

of the mother is transmitted to her offspring merely through the medium of the blood, or whether the characteristic lesions of the child syphilitic at birth are largely due to the degenerative changes in the placenta which have lately attracted the attention of eminent obstetricians as well as syphilographers, are also questions of interest.

There are two classes of congenitally syphilitic children, the curable and the incurable; the latter, surviving the dangers of syphilitic foetal life, soon succumb. The former class are best treated by mercurial inunction, the medicament being applied to the swathing bands of the infant.

Respecting the danger to the practitioner referred to by the reporter as occurring in the management of syphilitic patients, Dr. Hyde remarked further, that it was a significant fact, that the large proportion of medical men thus infected, are either of uncleanly habits or were accidentally inoculated while making the vaginal touch, the finger thus situated being bathed with the moist secretions of the part and being subjected to a high temperature admirably calculated to favor the contagious process. Under such circumstances the cutaneous integument of the finger becomes a quasi-mucous surface, and, as such, incurs the dangers of exposed mucous surfaces.

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#### THE CHICAGO MEDICAL SOCIETY.

*Meeting March 6, 1876.*

Dr. N. Bridge reported a case of perityphlitis in a female, aged about forty, where the disease had existed for three or four weeks, following obstinate constipation and impaction of fecal matter in the cæcum and ascending colon. The bowels had been emptied early in the progress of the case by cathartics and injections—several soft bilious dejections following a larger discharge of hard

scybalous masses, and the tumefaction in the ascending colon disappearing. There was a slight tumefaction in the ileo-caecal region that was exceedingly tender to the touch, and after each movement of the bowels was painful often for several hours. Pain was produced in this part and in the groin on flexing the right thigh; at times it was quite impossible to move the thigh. Late in the case, the glands in the groin became slightly enlarged and very tender. The temperature had been one to two degrees (F.) above the normal in the morning, with an increase of one to two degrees in the evening throughout, and the pulse had ranged from 75 to 110. The tongue had been intensely red early, but becoming less red and more moist toward the termination of the case.

There were during much of the time night sweats, and the general prostration was considerable. Although a small quantity of purulent matter was discharged from the vagina, it could not be demonstrated by examination as coming from the point of inflammation.

Two weeks after the bowels were emptied, or supposed to be, there occurred half a dozen discharges, in three or four days, of large, hard, and, many of them, very dry masses of fecal matter in large quantity. These discharges were, in most instances, induced by injections and small doses of castor oil. Following them the patient speedily got well. She had eaten little or nothing but milk and broths. The question of the age of the feces discharged during the convalescence was an interesting one. Were they in part the material of the old impaction, or had they been formed during the sickness? Dr. B. had only seen one of the dejections; this one was clearly recent in its formation, but the descriptions of others given by the patient and her husband would suggest the thought that, because of their dryness and hardness, they might have been incarcerated in the bowels from the beginning of the ailment.

In either case he was confident the soft fecal discharges which occurred during the first week of the case, and

following that of scybalæ, had come from the small intestines and *above* the seat of the accumulation in the *caput coli* and ascending colon.

Dr. H. M. Lyman had seen the case in consultation, and thought there was a slight grade of general inflammation in the intestinal walls, as well as that localized in the neighborhood of the ileo-cæcal region.

In the discussion of the case, Dr. Lyman believed it perfectly supposable that the fecal matter finally discharged had been formed during the existence of the inflammation. Intestinal contents in contact with inflamed mucous membrane, often become very dry and hard in a surprisingly short time. He thought this fact was not sufficiently borne in mind ; forgetting it, practitioners had been led to suppose that specimens of fecal matter—grown hard and dry in contact with inflammation—only a few days old, had been impacted in the abdomen as many weeks or months.

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#### ROCK RIVER MEDICAL SOCIETY.

(Reported by F. E. SHERMAN, M.D.)

The Society convened in Hartford, Nov. 20, pursuant to adjournment. President Senn in the chair.

Dr. Lynch read an essay entitled "The Relation of the Heart's Action to the Nervous System and to Mental and Emotional States." This was followed by the presentation of the following case : Mr. A—G—, æt. 36, farmer ; married ; of temperate habits ; never had had any severe illness. About two years ago, he noticed a sensation of numbness and pricking in the right upper extremity, which in a few weeks subsided and appeared in the feet, gradually extending upward until the hips were affected. After this his condition remained unchanged to the present time. He now finds it difficult to keep the lower extremities warm, and tires easily on walking ; the muscles feel sore, but he walks naturally

without loss of co-ordination. The abdominal and thoracic viscera are in a healthy condition and their functions performed in a natural manner. He has not been addicted to excess of venery, but there is a partial loss of desire. The battery indicates loss of sensory but normal motor power. On applying compresses he perceived two points  $3\frac{1}{8}$  inches apart, on the outer side of the left leg;  $\frac{1}{4}$  inch on the inner side. On the outer side of the right leg,  $7\frac{1}{8}$  inches; inner side 2 inches. It was thought to be due to atony of the nerves from mechanical compression by a morbid growth or to chronic spinal meningitis.

The regular discussion related to the Duties of a Physician in Natural Labor.

The next meeting will be held at West Bend, Dec. 4. Subject for discussion: "Non-inflammatory Softening of the Spinal Cord."

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#### THE NORTH CENTRAL MEDICAL ASSOCIATION.

(Reported by F. COLE, Sec.)

This Association, comprising the counties of Woodford, Marshall, Putnam, Livingston and La Salle, held its annual meeting at Wenona, Tuesday, December 7th. Dr. E. P. Cook, of Mendota, President, in the chair.

Drs. D. E. Thomas, of Lacon, and J. W. Evans, of Varna, were elected members.

The following reports were made: "The Germ Theory"—Dr. D. W. Lamme, Eureka.

"Differential Diagnosis"—Drs. A. Reynolds, El Paso, and Wm. O. Ensign, New Rutland.

"New Remedies"—Drs. G. F. Roberts, Lacon, and J. S. Whitmire, Metamora.

"Improvements in Surgery"—Dr. F. Cole, El Paso.

"Gynecology"—Dr. E. P. Cook, Mendota.

The following officers were elected for the ensuing year: Drs. I. H. Reeder, Lacon, *President*; A. Reynolds, El Paso, *Vice-President*; F. Cole, El Paso, *Sec'y and Treasurer*.

The president appointed the following committees to report at the next meeting:

“Bloodletting in Acute Inflammation”—Drs. J. S. Whitmire, Wm. O. Ensign, A. Reynolds.

“Plaster of Paris in the Treatment of Fractures”—Drs. I. H. Reeder, D. E. Thomas, Enoch Blanchard.

“The Study of the Natural History of Disease”—Drs. G. Newkirk, G. F. Roberts, J. W. Evans.

“The Best Means to Encourage and Sustain Local Societies”—Drs. F. Cole, L. G. Thompson, W. L. Downey.

Resolutions were passed, asking that local and State medical societies encourage a higher standard of medical education. Also, that Drs. Whitmire and Roberts be requested to publish the portions of their papers pertaining to original research with New Remedies.

The following delegates were appointed:

To State Medical Society—Drs. E. Blanchard, Minonk; I. H. Reeder, Lacon; D. W. Lamme, Eureka; Wm. O. Ensign, New Rutland.

To American Medical Association—Dr. F. Cole, El Paso.

Adjourned to meet at the same place in one year.

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## Hospitals.

### COOK COUNTY HOSPITAL.

Service Prof. J. P. ROSS.

(Reported by D. A. K. STEELE, M.D.)

**CASE 1. *Progressive Locomotor Ataxia.***—W. H. S., æt. 28, bricklayer, American; admitted Sept. 15, 1873. Patient was in the army as drummer for twenty-one months. For six months afterwards he was employed as a government teamster. In both situations was constantly exposed to changes of temperature and frequent wettings. He drank occasionally, enjoyed pretty good

health until about six years ago, when one evening he suddenly became very faint and dizzy and was obliged to go to bed. During this attack, which lasted about twenty minutes, he had no pain but a great difficulty in breathing. Slept all night and was able to work the following day. With the exception of an attack of intermittent fever which continued more or less severely for one year, he was well until about sixteen months after the first attack, when one evening while walking the streets he again became weak and dizzy and was obliged to sit down. Carried home he was ill during the next two months, seized with the same sensations whenever he attempted to walk, while he felt quite well when sitting down. Appetite was good. At this time he also noticed that he could not walk well in the dark, that he would get dizzy on stooping over, would fall as soon as he shut his eyes. Ever since this time (for the past three years) he has suffered from this difficulty in walking in the dark or with his eyes shut, and has been subject to attacks of faintness and vertigo, has occasional cramps of the muscles of the calf of leg.

Patient well nourished ; pulse, 54 ; resp. 24 ; appetite good ; bowels constipated. Is unable to stand with eyes closed and heels approximated, immediately staggers and would fall if not supported. Is unable to walk with eyes shut, and has to watch his movements carefully when walking with open eyes ; sensations good in the limbs ; arms seem to be but little affected ; can touch any part of the body with the fingers when the eyes are closed. After a brief treatment with fluid extr. ergot the patient left the hospital Oct. 5.

*CASE II. Cancer of Pylorus.*—E. M., aet. 40, Irish laborer ; admitted Oct. 13, 1875. Was perfectly well until last February, when he was attacked with vomiting and severe pain in the stomach ; pain was lancinating in character, and has continued, more or less, ever since. Could not retain his food ; has at times diarrhoea ; has lost seventy-five pounds in weight, and is very much

emaciated ; tongue furred ; pulse rapid and feeble ; has severe pain in stomach, cries out as if in great agony ; frequent vomiting. Lungs and heart normal ; can not find any tumor in hypogastrium by palpation. Patient evidently was failing rapidly, and he died Oct. 15.

Autopsy twelve hours after death. Find a mass of schirrhous deposit at pylorus and in tissues about it. Secondary cancerous deposit in liver ; other organs healthy.

**CASE III. *Cirrhosis—Dropsy.***—C. M., æt. 36, laborer, German. Patient was well until about six weeks ago when he began to be troubled with shortness of breath when he walked fast ; occasional pain in the left chest and shoulder ; appetite good ; bowels regular.

Three weeks ago his feet, legs and abdomen began to swell, and have continued swollen ever since. On admission well nourished. Skin normal ; tongue large, flabby, and slightly furred ; urine high colored ; feet and legs œdematosus ; abdomen contains fluid.

Physical examination reveals first sound of heart almost purely valvular, no heart murmurs ; no albumen in urine ; liver irregular.

Ordered B. Ext. Colocynth Co. gr. ij.; Potass. Bitart. 3 j. Ter die.

24th. B. Quinia Sulph. gr. ij. ; Strychnia Sulph. gr.  $\frac{1}{2}$  ; Tr. Ferri. Chlor. gtt. xv. Ter die.

Oct. 19th. Patient leaves hospital much relieved ; scarcely any dropsy left ; only slight œdema of the feet and ankles during the day.

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CENTRAL HOSPITAL FOR THE INSANE, JACKSONVILLE, ILL.

*Case of Peritonitis from Perforation of the Stomach by Foreign Body—Death—Post-mortem.*

(Reported by F. C. WINSLOW, M.D.)

F—F—, male, æt. 26 ; insane for a year, and during the six months of his residence here was filled with delusions—constantly seeing and conversing with ghosts, and more recently manifesting suicidal propensities.

March 6th. He was visited by friends, and although it was remarked that he was not quite as well as usual, yet he was dressed and around the ward in his ordinary manner.

7th. In the morning was too sick to leave his bed, and on examination was found lying on his back with the knees drawn up, abdomen very tender and slightly tympanitic, diaphragm fixed, breathing chiefly thoracic. The face was flushed, skin hot, tongue dry, brown and tremulous; pulse 120 and wiry in character. He had vomited a little greenish matter in the morning, and refused all ingesta except cold water. The case was pronounced peritonitis, and strong suspicions were entertained that he had swallowed some foreign substance, as a piece of glass or metal.

Without pausing to detail the history, it is sufficient to say that the case presented from day to day an aggravation of the symptoms, and terminated fatally on the 12th.

Post-mortem four hours after death; *rigor mortis* beginning; abdomen tense, but not enormously distended; an incision was made extending from the ensiform appendix to the pubes, and the structures carefully divided down to the peritoneum. On opening the peritoneal cavity a small quantity of serous fluid containing flakes of lymph was found. Both the abdominal and visceral peritoneum—the latter particularly—were found highly congested and inflamed. The stomach contained a little greenish fluid, while the small intestine was almost empty. On passing the hand behind the stomach to remove it, the operator felt a sharp body and withdrew an ordinary sewing needle, the point of which protruding through the gastric walls he had perceived. The intestines were removed entire, and evidences of severe inflammation throughout the small intestine were everywhere present. A condition of positive softening was observed in one portion about ten or twelve inches long, this particular portion of the intestine marking the location of another foreign body—a piece of knitting needle over two inches long. The large intestine was filled with thin yellowish fecal matter.

The needle was found in the stomach, and it is supposed the irritation caused by the point against the diaphragm increased the pain of the respiratory movements always observed in peritonitis.

## Summary of Progress in the Medical Sciences.

### I. SURGERY.

1. *Fatty Embolism as a Cause of Sudden Death after Injuries of the Bones.* (The Med. Record, New York, Jan. 29, 1876; Berlin Klin. Wochenschrift, Nov. 1 and 8, 1875.)

Prof. V. Czerny, of Freiburg, taking the reports of two cases as a text, discusses this subject mainly in its clinical aspects. The first case was that of a healthy man, aged 24, who, Nov. 16, sustained a simple fracture of the right thigh in its upper third, caused by falling off a sand bank. The surgeon who was called to him, found that he suffered little pain at the seat of the fracture, but could not lie down without difficulty, especially on his back, and could not breathe easily.

On the 18th, the swelling having subsided, a pasteboard splint was applied, the patient at the time finding it very difficult to maintain a half-sitting posture. On the night of the 20th, great dyspnoea and depression suddenly manifested themselves, without inflammation, and he died on the 22nd.

The authorities subsequently had the body disinterred and examined. The fragments of bone were in proper position, but both lungs were full of venous blood, and the membranous substance, and blood vessels of the brain also, were similarly filled. He cites the opinion of Wagner, who, in 1865, states that a sudden fatty embolism was capable of inducing hyperæmia of the lungs, œdema and death; and in 1866, of Busch, who established that the medulla of the bones, when crushed, was taken up by the veins and lymphatics, and caused emboli in the lungs, and death.

Czerny's second case is as follows:

J. S., aged 32, a strong and healthy man, sustained a simple fracture of the right thigh just below the middle, the consequence of a fall from a scaffold. He also had a flesh wound of the chin which was sewed up, and dressed antiseptically. He was taken at once to the clinique, where the limb was dressed and ice applied. The patient complained very little of pain, although quite conscious. This occurred Nov. 14, 1874. On the following day, Prof. C. in a clinical lecture on the case, mentioned that although free from fever, the previous day, his temperature that morning was nearly 103° F., and he gave a guarded prognosis. In the evening the temperature was almost a degree higher. Although at night he was free from pain, he was sleepless (?), and had at intervals of three hours doses of about one-eighth gr. each of morphia. Some hours after midnight he was found comatose, with deep and frequent respirations, accompanied by coarse râles. The chest was resonant on percussion. Pulse 100, full and strong. He was bled from the arm, but obtained no relief and died at half past seven, thirty-eight hours after the injury.

At the autopsy, both lungs contained air and fluid. The left side of the heart was contracted, and there were coagula in both sides. The vessels of the pia mater and of the brain were distended with blood, and in both of these were numerous small ecchymoses. There were extensive extravasations of blood at and about the seat of fracture, but the femoral vein and artery were not wounded. The microscope revealed throughout the lungs a firm injection of all the smaller arteries and the capillaries, with clear fluid fat. Likewise in the brain, corresponding to the small ecchymoses, were branching fatty emboli in the vessels. Fat was also in the vessels of the kidneys and liver. The fatty embolism of the lungs was considered a sufficient cause of death.

Prof. C. quotes the statement from Busch that fatty embolism begins in the first few hours after the injury. The difficulty of respiration would point to this condition. Possibly the slight sensitiveness to pain may also be symptomatic of it.

Shock cannot be held to explain a death after injury, when an interval of several hours of good condition has intervened between the injury and death. He concludes that fatty embolism is of essential significance only after injuries of the bones, and perhaps osteo-myelitis. We may, continues Prof. C., suspect this condition when after such injuries a rapid failure sets in, with interference with the circulation in the lungs; and secondly, in the general capillary circulation, without other cause, and very shortly after the injury is received.

2. *Luxation of the Thumb Backward.* FARABEUF. (*L'Union Médicale*, No. 25.)

The original paper of this author is admirable, and the anatomical points involved are carefully discussed, many experiments having been made on the cadaver.

The essential cause of the irreducibility of luxations of the thumb backward, is the interposition of the glenoid ligament between the articular faces; but the sesamoid apparatus to be found in this ligament and in especial the external sesamoid bone, are the chief factors.

The whole question is made to turn on the mode of the articulation of the sesamoid bones with the phalanx. The latter is so disposed in the articulation, that it will permit of extreme flexion, but not of extreme extension—cartilage cannot be applied to cartilage. The sesamoid bone and the phalanx (or rather the articular face of the latter,) form a right angle which F. compares to that of a table-leaf which can be lowered but cannot be raised to a higher level than that of the table itself.

If we suppose a movement of extension in the thumb sufficient to tear the glenoid ligament, where does the rent occur? The mode of insertion of the glenoid ligament upon the metacarpus and the phalanx enables us to understand that the metacarpal insertion will first yield. In 100 experiments, F. has found the phalangeal insertion torn but once. It can then be accepted as a fact, that when the extension of the thumb

is sufficient to rupture the glenoid ligament, the sesamoid bones will remain attached to the phalanx.

If, in the movement of extension, the sesamoid bone does not slide beyond the cartilaginous face of the metacarpus, the luxation is *incomplete*. If the phalanx is carried more or less further back upon the dorsum of the metacarpus, carrying with it the sesamoid bone, the luxation is *complete*. Finally, there is a third variety named *complex*, the mechanism of which is carefully studied, and which accounts for the irreducibility of certain luxations.

When the phalanx is dislocated upon the dorsum of the metacarpus, it is maintained in this position by the muscular button-hole formed by the sesamoid muscles. From this it results that if the thumb be bent downward, the sesamoid bone is reversed, so that its cartilaginous face looks upward, and it becomes situated behind the phalanx instead of in front of it. It is this inversion of the sesamoid bone which constitutes the *complex* luxation.

Given this disposition of the osseous surfaces, the difficulty lies in the impossibility of bringing the sesamoid bone down over the articular face. Reduction is possible in such cases only when the two articular surfaces are capable of separation to the extent of the length of the sesamoid bone—that is, to the extent of about six millimetres. But the intact portion of the ligaments resists this separation, so that the luxation becomes irreducible.

The reduction proposed by Farabeuf is based upon the reciprocal relation of the luxated surfaces. It is needful :

1. Never to flex the finger upon the metacarpus, for this may transform a *complete* into a *complex* luxation.
2. To commence by pressing the thumb backward if it has been depressed.
3. To seize the first phalanx with a pair of forceps, hold it at right angles to the metacarpus, and give it a movement in its totality from behind forward, so as to force off the sesamoid bone. It is the phalanx itself which does this.
4. If the luxation is several days old, to give it a lateral motion, so as to determine a rupture of the lateral ligaments.
5. In cases of irreducible luxation, to make subcutaneous section of the two lateral ligaments, and reduce afterward.

"En résumé," says the reporter of the Surgical Society, "M. Farabeuf seems to me to have demonstrated that the cause of irreducibility in thumb luxations, arises not only from the interposition of the glenoid ligament, but further and more particularly from the turning over of the external sesamoid bone, which becomes, as it were, buttressed upon the dorsum of the metacarpus. He has shown also the exceedingly important rôle of the ligaments and the muscular button-hole, though these are but secondary factors. He has produced before me upon the cadaver irreducible luxations; and I have been in position to assure myself of the reality of the mechanism he describes. The author has collected everything

available upon this subject from the literature of all nations, and has produced a work which displays erudition, critical comparison and much original observation. It is accompanied by a large number of figures ably executed by the author."

3. *Radical Cure of Hernia.* PROF. NUSSBAUM. (*Aug. Med. Central-Ztg.*, 18, 1876.)

The favorable results obtained by Lister's antiseptic treatment of lesions of the peritoneum encouraged the professor to attempt the cure of hernia by catgut sutures in a few cases where an operation was imperatively indicated by the impossibility of getting a truss to retain the rupture.

After a thorough evacuation of the bowels by cathartics, the patient was narcotized and his scrotal hernia was well exposed by a long incision through the integument and the other coverings. All adhesions of the hernial sac with the testicle and spermatic cord were severed, and after a careful reposition of the intestines contained in it, the sac was sewn up by catgut sutures as near the inguinal canal as possible.

One centimetre below these sutures the empty sac was cut off and the upper end of it, with the stitches, pushed into the abdominal cavity. The external wound was then closed by antiseptic silk sutures, and the case was treated by a strictly antiseptic dressing.

The healing process went on unattended by any untoward symptoms, and the immediate result was exceedingly satisfactory. Still the professor thinks it premature to venture a definite opinion on this operation.

4. *A Remarkable Case of Skin-grafting.* DR. AUG. REVERDIN. (*Deutsche Zeitschr. f. Chir.*, vi, 418.)

A woman, 21 years of age, while working in a factory was caught by her hair in the machinery and the whole scalp was torn off her head. This accident occurred in April, 1872, and on October 10, of the same year, she was admitted to Prof. Lücke's clinic, in Strassburg, with an immense granulating wound which measured 14 inches (35 centimetres) from the root of the nose to the back of the head, and 11 inches (28 centims.) from one ear to the other. The upper part of the left ear was torn off with the scalp. The surface of this wound exhibited pretty good granulations and a copious secretion of pus, and was surrounded by a stripe of cicatrized and very vascular skin, about one inch (2 to 2½ centims.) in width.

After eight days of dressings with strips of adhesive plaster, the granulations had a more satisfactory appearance and the grafting process could be commenced.

For excising the grafts, Dr. R. used a lance-shaped knife (like the iridectomy knife) the blade of which was concave at the upper and convex at the lower side. From the knife the excised grafts could easily be removed to the wound with a needle where they were secured in their places by plaster strips. When the grafts had taken, the surrounding granulations were touched by lunar caustic in order to favor the formation

of epidermis. After seven months the whole wound was healed, and the head was covered with a sound cicatrix in which large blood vessels could be seen.

During the treatment the doctor made various experiments with transplanting pieces of the skin of dogs and rabbits, and also with larger pieces (one to two inches square) of human integument taken from the amputated leg of a boy. The latter transplantations were successful, while those made with animal skin all failed.

## II. PRACTICAL MEDICINE.

### 1. *Fatty Degeneration of Liver and Kidneys Consecutive to an Extensive Burn.* COUSTON. (*Le Progrès Méd.*, No. 9.)

A patient (male, 27 years old, who had enjoyed previous health without syphilitic, scrofulous, tuberculous or alcoholic antecedents), in consequence of an accident with a kerosene lamp, was extensively burned upon the posterior part of the trunk, from the lumbar region to base of the mucha. The pain, excessive at first, was partially relieved on the second day afterward. There was no cerebral excitation, only moderate fever with anorexia, dyspnoea and dysuria, with a red and very scanty urine. A persistent diarrhoea supervened, without colic or abdominal pain. The abdomen remained supple, and there was no blood in the stools. Then followed profuse sweating, separation of sloughs, extensive suppuration of the burned surface, formation of eschars over the trochanters and shoulder blades, whose fall left bare the articular capsules, great prostration, and finally death.

At the autopsy the lungs were found intensely congested, and the liver enormously hypertrophied and fatty in all parts save in the lobus Spigelii. The renal substance was also in a granulo-fatty degeneration.

The femoral and external iliac veins of the left side were filled with a clot, which terminated exactly where the primitive iliac vein arises. In detaching the femoral vein, some collateral branches were divided, which gave exit to a drop of pus. These vessels were buried in the muscles of the external region of the thigh. It was difficult to decide whether they communicated with the trochanteric and sacral abscesses. In the femoral vein, at the points where the latter opened, were small purulent foci, perfectly encysted and separated from each other by portions of clots, which were exclusively fibrinous.

Duret remarked that venous thrombosis following a burn was rare, but had yet been noted (Guy's Hospital Reports). He had recently seen peculiar cerebral phenomena after a severe burn of the surface of the chest. There was undisturbed intelligence, but aphasia and hemianæsthesia, which disappeared subsequently, and which he was disposed to refer to encephalic thrombosis.

2. *Mumps: its Relation to the Eruptive Fevers.* COLIN. (*La France Méd.*, No. 18.)

From the comparison instituted it is evident that: (a) mumps and the exanthematos fevers have the same mode of transmissibility; (b) immunity conferred by a first attack; (c) no sporadicity; (d) frequency among children and soldiers; (e) slow and successive spread among various classes of people, when the element of time cannot contribute an appreciable influence—the disease seeming to lose its power in one situation before its extension to another; (f) but the point of contact between mumps and the eruptive fevers seems to be the simultaneity of the epidemics of the two—among the last named especially measles, which seems to precede or accompany mumps.

There seems to be likewise a species of affinity between these disorders, so far as regards the conditions which produce the "medical constitutions" in each.

A clinical resemblance may be discovered in the period of incubation and invasion, in the febrile movement, and the secondary fever which ushers in metastatic orchitis. It is true, however, that in adults the affection may be initiated by a period of calm, which does not recall the febrile movement in the pyrexias, and also that the involvement of the testicle, primary or secondary, may be so sudden and unexpected as to suggest traumatism or a venereal affection. There are other cases in which the general symptoms are severe: typhoid symptoms, convulsions with a fatal termination, intense articular pains, an exanthema or enanthema of variable degree, anasarca, with albuminuria. Colin cites cases where the latter complication has been noted, and where the metastasis has been to the kidneys instead of the testes. One fatal case suffered from orchitis, acute albuminuria and uremia.

3. *Antagonism between Heart Disease and Tuberculosis.* PETER. (*Gazette des Hôpital.*, Nos. 97 and 99.)

There is no such absolute antagonism. Tubercles develop by preference in the rudimentary tissues (connective), and in organs or parts of organs of minimum function. Thus it is that tubercles are found at the pulmonary apices, the parts of the lung which have the least work to do because of the shortness of the upper ribs, their relative immobility, and the course of the superior bronchi, relieved by the current of air from the sense of weight. In mitral affections the inferior portions of the two lungs are, at a certain period, in a stage of chronic congestion. It results from this that the upper part of the lungs, in order to perform a supplementary labor in haematoses, rendered necessary by this congestion, are compelled to do extra work. From this functional hyperactivity it happens that the pulmonary apices have a diminished tendency to become tuberculous. This explains the pretended antagonism between the two disorders.

But, at the onset of mitral insufficiency, when there is less interference with the circulation, and the inferior lobes are not yet affected with pas-

sive congestion, the superior lobes are then not in such a condition of exalted functional activity as to make immunity probable. Tubercles may then be developed if the patient is placed under such conditions as will ordinarily favor this process—bad hygiene, poverty, etc.

There is, therefore, no absolute immunity of the pulmonary apices for tuberculosis when there is coexistent disease of the heart. All is subordinate to the period of the cardiac disease, to the nature of the latter, and to the general condition of the organism.

(We were recently consulted by a gentleman who was suffering from mitral insufficiency with a loud systolic murmur, who had had several haemoptyses, and unmistakable evidence of tuberculosis of the right pulmonary apex.—ED.)

4. *Thoracic Hyperesthesia and its Relation to Acute Tuberculosis.* BOUCHUT. (*Gazette des Hôpits.*, No. 64.)

B. discovered in a child, who presented the evidences of a typhoid fever, tubercles of the choroid, the signs of an acute tuberculosis. There was also thoracic hyperesthesia. This last symptom, which he has several times observed, should be added, he thinks, to the list of symptoms of acute tuberculosis. It points unmistakably to a lesion of the pleura which autopsies have demonstrated. This hyperesthesia is not to be found in typhoid fever, for, when discovered, it is in every case not limited to the chest, but has extended to it, to the membranes, etc. The same is true of the tegumentary hyperesthesia of tuberculous meningitis. Therefore whenever, in a disease of a typhoid type, there exists a thoracic hyperesthesia, not complicated by hyperesthesia of the limbs, it indicates dry pleurisy and acute pulmonary tuberculosis.

5. *Progressive Muscular Atrophy.* WM. ALEXANDER, M.D. (*Lancet*, March, 1876.)

Dr. A. records five cases of this disorder, with comments as to its nature. The cases resembled each other in having nervous symptoms at the beginning, in the onset being gradual, in the upper extremities being principally affected, in the absence of any hereditary quality or any specific taint, in the slight improvement following the constant current and shampooing, and in the irregular manner of the advance of the disease. The author believes the disease has a nervous and not a muscular origin, and for the following reasons: 1, The nervous symptoms at beginning—a feeling of “pins and needles,” neuralgic pains, numbness and susceptibility to change of temperature in the affected part. 2, On the muscular theory the course of the disease is inexplicable—it invades one hand, passes up the arm for some distance, then attacks the opposite hand; it attacks one bunch of muscles, and passes by another bunch in close contiguity. “On the theory that it is a disease of the cord, its course is just what we ought to expect.” 3, The treatment that was most beneficial was such as would, we might suppose, have made the disorder worse had its origin been muscular and not nervous. 4, The *post mortem* made with

microscopic examination of the cord showed the disease in this structure to be far in advance of the change in the muscles—the reverse ought to be true did the affection begin in the muscles. 5, The fact that spinal cords taken from patients who had died of the disease have, on a rough examination, been thought to be healthy, does not negative the theory of nervous origin.

6. *On Unique Anatomical Appearance in General Paralysis.* W. H. DEWITT, M.D. (*Vineet. Lancet and Obs.*, April, 1876.)

The history of this case offered nothing unusual for a case of general paralysis of the insane. Death occurred in about a year from the beginning of the disorder. During the early months there was the usual exaltation and vast "intellectual pretensions," with great irritability of temper. The temperature "was above the normal during the whole course of the disease."

The dura mater was found much thinner than normal, and presented at points a cribriform appearance. Between the visceral and parietal layers of the arachnoid, there was a false membrane that enveloped the entire brain structure. "It was but slightly adherent, and easily detached without destroying its texture." The arachnoid was opaque, and the pia mater was only slightly congested. The convolutions were flattened and the cortical substance was thin.

Dr. D. believed the thinning of the dura mater was due to the pressure by the false membrane, and that the latter was an appearance not previously reported.

7. *Intussusception in an Infant—Recovery.* F. L. HAYNES, M.D. (*Phila. Med. Times*, March 18, 1876.)

The patient was seven months old, and had always been constipated. On symptoms of intestinal disturbance, castor oil was given, which operated well. Diarrhoea followed—in two days streaks of blood characterized it. The next day there were more blood, mucus and tenesmus; injections of starch and laudanum, and stoppage of diarrhoea, with beginning of vomiting of greenish fluid. The day following came stercoraceous vomiting, tympanitis, dullness on percussion, and tumefaction over descending colon, with great prostration. A tumor could be felt by the finger in the rectum, a soft, velvety mass filling the whole space, and having an oblong orifice in the centre. The child was suspended by his heels, the tube of a stomach pump was pressed far into the rectum, and water forced in by means of a Davidson syringe. After repeated attempts no good was accomplished. Later in the day another attempt was made in the same way, when the tumor disappeared. The child now made a slow recovery. Flatus was at once evacuated by passing a tube into the rectum.

8. *Intra-Cranial Aneurism—Recovery Under Large Doses of Iodide of Potassium.* W. M. E. HUMBLE, M.D. (*Lancet*, March, 1876.)

This is a case previously reported of an aneurism in the cavernous sinus. For seven and one-half months the bruit was so distinct that the patient

constantly heard it, and was much annoyed by it. During five months Dr. H. was able to hear it with the stethoscope. Three and one-half months after the first symptoms appeared, the case was put upon the regular use of the iodide. Most of the time thirty-six grains were taken daily. The general health during the four months of the administration of the drug continually improved. At the end of this time the bruit suddenly stopped. The patient had some neuralgia and other unpleasant symptoms of lesser moment, but at the end of five weeks there had been no return of the bruit, and the aneurism appeared to be cured.

9. *Paracentesis of the Pericardium—Recovery.* DR. BURDER. (*Lancet*, March, 1876.)

A carpenter, sixty years old, had had, forty years before, and again two years later, two attacks of rheumatic fever. Subsequently, and until about Christmas, 1874, his health was good. At the last-named date he was attacked again with rheumatism, which kept him in bed a week. In April, 1875, after having had a cough for some days, his feet began to swell.

He was found, April 26th, with general anasarca, shortness of breath and feeble pulse. The heart's action was rapid, irregular, with an indistinct systolic bruit. Two days later he was apparently moribund. The signs indicating considerable fluid in the pericardium, he was aspirated, and forty-two ounces of the material—pale, straw-colored—removed. The needle was inserted between the 5th and sixth ribs, and one inch to the right of the nipple. Toward the close of the operation the apex of the heart was felt to strike the needle once or twice, but it ceased on placing the needle more horizontally. The patient was easier immediately after the operation; in a few hours he was very much easier. Recovery resulted.

10. *The Relation of the Teeth to Disturbances of the Nervous System.* (*The Dental Register*, March, 1876.)

The following cases are reported:

A woman, unmarried, twenty-five years old, healthy, and with teeth better than the average, had at times, for months, paralysis of the left arm. After receiving a variety of treatment without avail, her teeth were examined by a dentist, when the nerve of one of the wisdom teeth was found to be bare. The tooth was extracted, when the palsy was cured.

A woman of good health, aged twenty years, was married; soon after which she had epilepsy. She had treatment, but grew worse for three years, when, on advice, she had all her diseased teeth extracted; this included all except the eight front ones of the lower jaw. She took tonics and was well.

A married woman of twenty-five, had never borne children. Her teeth and other appendages were perfect. She had toothache regularly at her menstrual periods.

## III. OBSTETRICS.

1. *Fatal Death before the Termination of Pregnancy, from a Knot in the Umbilical Cord.* CANIVET. (*Le Progrès Méd.*, No. 6.)

A woman in the 8th month of her fifth pregnancy could not walk by reason of extensive abdominal enlargement. Delivery occurred at term of a first fetus (female) dead, and presenting by the summit, with spontaneous rupture of the bag of waters. Soon after a new pouch of waters presented, ruptured, and was followed by the expulsion of a normal living child.

The first infant was so macerated that the epidermis was readily detached from the dorsum. The belly was retracted, but there was no appreciable lesion; and in height and volume it corresponded to the living child.

At ten centimeters from the umbilicus a knot was forcibly tied in the cord which was 95 centimeters in length, and wound three times about the neck of the fetus. The portion of the cord between the neck and the umbilicus was red and congested, while that extending from the knot to the placenta was, in color and appearance, quite normal. The knot itself was closely tied and exhibited a distinct coagulation of blood in the umbilical vessels at that point. The cord was slender, but the placenta normal.

The interest in this case lay in the death of the fetus, which, judging from the maceration, had occurred several days before birth. The majority of authors have decided that those knots are never sufficiently constricted to interfere with the circulation and induce the death of the fetus. (Mauriceau, Beaudelocque, Cazeaux, Tarnier.) One single case, (reported by Voetz) has been published in the *Gazette des Hôpitaux*, 1842.

Guéniot stated that these knots are rarely drawn sufficiently tight to interfere with the circulation and produce dangerous effects upon the fetus. This results from the material with which the cord is smeared, and which prevents its constriction so perfectly that after delivery, if it be knotted artificially, it will be found difficult to tie it tightly unless this smegma be first removed. Besides, the incessant motion of the arterial fluid tends to prevent the accident by loosening the knot. In this case death was probably determined by the three turns about the neck which increased the vascular disturbance.

2. *Tubal Pregnancy.* ALBU. (*Berlin Klin. Wochenschr.*, Feb., 1876.)

A woman was seized with vertigo, malaise, diarrhoea, and violent hypogastric pain, followed by repeated syncope. Up to date her health had been perfect. She had not menstruated for two months. The abdomen and the uterus were exquisitely sensitive to the touch. As she was living in concubinage, poisoning was thought to be the cause. Shortly after the visit of her physician, she went into collapse and died.

The autopsy revealed rupture of the left fallopian tube, from which an haemorrhage had occurred. The membrane of the ovum was also torn, the latter having been fecundated and increased to the size of a nut.

Albu remarked that Maschka had already called attention to the symptoms of poisoning exhibited in cases of pregnancy of the tube, viz: abdominal pain, extreme feebleness, nausea, pallor of the surface, smallness of the pulse, collapse, cramps, convulsions and sudden death.

Heim, in his thesis on pregnancies of the fallopian tube, gives the details of 32 cases observed by himself.

3. *Uterine Mucous Membrane Expelled without Metrorrhagia—Probable Extra-uterine Pregnancy.* HUTINEL. (*Le Progrès Méd.*, No. 7.)

A woman, 25 years of age, had severe pelvi-peritonitis after her second confinement. She was well for two months when she had menstrual suppression. She then experienced some pain, her limbs became heavy. She grew larger, and had dyspepsia without vomiting. These troubles were temporarily relieved when she had violent abdominal pain, syncope, bilious vomiting, abdominal distension, and an exsanguine facies without apparent loss of blood. Acute generalized peritonitis followed.

On July 26, her skin was of a waxy yellow hue, and the conjunctivæ, gums and lips were almost bloodless. The belly was equally distended in all directions and so sensitive that she could not endure the contact of the hand. Some greenish vomiting; pulse, 120; temp. 40° C.

On July 28, there was relief of symptoms and a triangular membrane was removed from the vagina, half a centimetre thick, villous upon each face, slightly mamelonnated, but smooth, and presenting pitted depressions which could be recognized as the glandular orifices of a section of uterine mucous membrane—a recognition confirmed by the microscope.

The distinct symptoms of internal haemorrhage preceding the peritonitis and the expulsion of the membrane without haemorrhage externally, pointed to extra-uterine pregnancy.

4. *Hydatids of the Womb.* McCLELLAND. (*Rich. & Lou. Med. Jour.*, Feb.)

In the *Richmond and Louisville Med. Journal*, Feb., Dr. M. A. McClelland has reported an instance of this rare disease. The patient, a primipara, aged 34 years, thought herself five months advanced in pregnancy. Had been flowing for several days when first seen; paroxysmal pains; os somewhat opened, through which an uneven mass was felt. The expulsion of the foetus was soon followed by that of the diseased placenta which was made up of cysts filled with clear serum and varying in size from that of a mustard seed to that of a Concord grape. The foetus was well formed, some ten inches in length, and gasped a number of times.

5. *Rupture of Uterus.* FULLER. (*Cin. Lan. & Obs.*, March.)

Dr. S. W. Fuller reports this case in *Cin. Lancet & Obs.*, March. The patient was a stout woman with pendulous belly, who was already the

mother of five children. When first seen the os was well dilated and the membranes ruptured. Six hours subsequently the head was just entering the strait in first position of vertex, when suddenly the pains ceased, the patient complained of pain in the region of the fundus uteri, and grew very restless. An attempt to apply forceps failed, and turning was decided upon. The lower extremities of the fetus were found quite in the abdominal cavity, but version and delivery were not difficult. The hand was subsequently passed through a very extensive rupture of the uterus into the peritoneal cavity; no clots were found; the placenta was lying loose within the uterus; the organs were contracted. The injury was followed by high fever, but at the end of seven weeks the patient was able to sit up.

Rather more than two years after this accident which has been described, the patient safely gave birth to a six-months fetus; the placenta being everywhere firmly adherent.

6. *Presentation of Four Hands.* STIEBELING. (*N. Y. Med. Journal.*)

Dr. Stiebeling was called to the case; the membranes were intact; os well dilated. The presentation of hands could be distinctly made out, and it was decided to perform version; upon rupturing the membranes, two hands were met, and in going higher two other hands were encountered, and then two heads. A foot was pulled down and the delivery of a boy soon followed; the second fetus, also a male, was soon delivered in the same manner. Mother and children did well.

7. *Hæmorrhage from Abortion.* PALLENT. (*N. Y. Med. Rec.*, Feb. 12.)

Concerning haemorrhage from abortion, Dr. Pallen said, before the New York Academy of Medicine, (*N. Y. Med. Rec.*, Feb. 12), that he always dilated the cervix with his hand or other means, and removed the fetus and placenta at once, as a guard against haemorrhage and septic infection.

In the discussion of Dr. Pallen's remarks, Dr. Mundé said that he was of the opinion that no harm would follow if the placenta was left in the uterus for a number of days; it would, as a rule, soon be found in the vagina.

Dr. Hubbard said that for twenty years he had left the placenta of abortion entirely alone. If haemorrhage is severe, he uses a tampon. In the great majority of cases, the placenta will be found loose in the vagina at the end of the second day. He regards this much safer practice than forcibly opening the cervix uteri for the removal of the placenta.

8. *Induced Lactation.* GILBERT. (*Louisville Med. News*, March 11.)

An instance of this is reported by Dr. Gilbert, (*Louisville Medical News*, March 11). The subject, a married and childless woman, took an orphan child three weeks old. Artificial feeding disagreeing with the infant, the woman, whose desire for children was strong, was induced to allow the

infant to take her nipple. A poultice of leaves from the castor oil plant was applied to the breasts, and teaspoonful-doses of castor oil were given every three hours. At the end of twenty-four hours, a peculiar sensation was experienced in the breasts, and in three days the function of lactation was well established. The infant thrived well.

9. *Medico-legal Evidence of Independent Life in a New-Born Child.*

In a little pamphlet with this title, Dr. Gaston (Montgomery, Ala.) has called attention to the fact that the function of respiration alone is evidence of extra-uterine life; and that the fact that the foetal heart has pulsated after birth is not sufficient evidence in a medico-legal point of view.

10. *Gestation Extending Three Hundred and Six Days.*

Dr. Graves reports the case in *Boston Med. & Surg. Journal*, March 30. The subject, seventeen years old, was the wife of a sea-faring man. Three days before the husband sailed, the woman ceased to menstruate; sexual intercourse was had each of the two nights following. Three weeks after her husband left her, she had nausea, and Dr. Graves thought her pregnant. At the expiration of nine months, the Doctor was asked to hold himself in readiness to attend upon the woman as she was having some pain. During the night of the three hundred and sixth day from the departure of her husband the labor really began, and continued four hours; the woman giving birth to a healthy male child weighing ten and one-half pounds.

11. *The Physiological Cause of Muscular Contraction of the Gravid Uterus.*

Dr. Thomas Mays, (*N. Y. Med. Jour.*, Feb.,) in an interesting paper on this subject advances the idea that it is a condition of bloodlessness of the uterus during the last days of pregnancy which induces the contractions of the organ during that period, these contractions growing more forcible until labor has begun. He finds the explanation of this deficient blood supply to the uterus in the encroachment which the heavy gravid uterus makes upon the uterine supply vessels, by which the circulation through them is impeded. It is a little significant that this encroachment is greatest as term is approached, and coincident with the beginning of uterine contractions, when the lower part of the body of the uterus begins to contribute most to the development of the uterine cavity.

## IV. THERAPEUTICS.

1. *Whooping Cough Treated by Complete Etherization.* DR. S. D. POWELL. (Ex.)

At the last meeting of the Neurological Society, Dr. P. advocated the above cure for pertussis. The etherization must be continued forty or fifty minutes. He related about six cases in which this procedure had proved successful, though in one or two cases the anesthetic had to be given a second time. He hit upon this method of treatment accidentally from etherizing a child who had pertussis at the time, for the reduction of a fracture.

2. *Tooth Ache.* C. A. GUILD. (Clinic.)

Equal parts of collodion and carbolic acid, form a stiff jelly, which may be applied with a pine stick to the cavity of an aching tooth. The pain will be relieved almost instantly if it depend on an exposed nerve.

3. *Salicylic Acid for Articular Rheumatism.* DR. STRICKER. (Berl. Klin. Wochenschr.; Allg. Med. Central. Ztg., 19, 1876.)

Since Dr. Stricker first advocated the internal exhibition of the salicyclic acid for rheumatism, he has received a great many communications from professional friends confirming the good effect of the remedy on the disease. The success depends, however, very much on the purity of the acid. He puts his experience down in the following sentences:

1. The salicyclic acid seems to be a prompt and reliable remedy for fresh cases of genuine articular rheumatism.
2. It is not injurious to the human organism if given in hourly doses of 7 to 15 grains (0.5 to 1.0 grammes.)
3. Such doses can be continued longer in young and robust persons than in old and feeble ones.
4. It produces the signs of intoxication sooner with the latter than with the former.
5. This intoxication shows various grades; tinnitus aurium, dullness of hearing, and perspiration, are the ordinary signs, and yet they do not contra-indicate the further use of the acid.
6. To prevent a recidive the acid should be continued in small doses (20 to 40 grains pro die, for at least one week longer.
7. In chronic cases of articular rheumatism its efficiency is doubtful, and in so-called gonorrhoeic rheumatism it is very improbable.

4. *Opium and its Antidote.* DR. J. H. STEARNS. (Detroit Review of Medicine, April, 1876.)

It is admitted that opium, in its several forms, is the great antidote for pain, and in prescribing it the dose should be regulated by the extent and

severity of the pain, modified by the fact as to whether the patient's system has recently been accustomed to its use.

The custom of giving opium or morphine for mere sleeplessness can not be too highly reprehended, or to give it where the pains are fugitive or uncertain of duration, because should the pain disappear, the full force of the drug would be expended on the brain, with perhaps dangerous or fatal results.

As to antidotes for an over-dose of opium, the brain of the profession has been exercised to an alarming extent. I believe that atropia is now the fashionable thing to exhibit hypodermically.

Realizing that opium is the antidote for pain, and that otherwise deadly doses are carried off with impunity where the pain is excessive, we have only to reverse the proposition, and the question is solved, for we have pain as the antidote for opium. Finding the patient laboring under an over-dose of any opiate, proceed at once to inflict upon him a pain that will be persistent and continued at your pleasure. Remembering that the most excruciating torture is experienced by pressure upon terminal branches of the nerves, the most convenient way will be to apply pressure upon the ends of the thumbs and fingers. This can be done by using a small hand vice, or even the ordinary spring clothes-pins will answer every purpose, for it is astonishing to experience the amount of pain one of these little instruments will inflict with its persistent grip.

The inquisition found the thumb-screw the most effectual machine for torture that could be advised. Ephemeral and transient pains will be of little good; it is the steady and continued agony that accomplishes the work.

Accounts of cases treated on the theory indicated would be of little use, unless it commends itself to the judgment, and this paper is respectfully submitted to the readers of the *Review*, trusting that it will receive a careful examination, in the light of previous knowledge and experience with this powerful drug.

5. *Grindelia Robusta—Therapeutic Action and Chemical Analysis.* C. J. RADEMAKER, M.D. (*Louisville Med. News*)

I have used this medicine in several cases of chronic pneumonia, bronchitis, and in asthmatic troubles, whether depending on cardiac lesions or structural disease of the lungs or bronchial tubes, and my patients were invariably benefited by it to some extent.

Mrs. F., aged 48, had chronic pneumonia of about two years' duration, with considerable purulent expectoration. Physical examination of the chest revealed flatness of the entire left lung. She suffered with considerable dyspnea, and had used all the expectorants, oils, anodynes, tonics, alteratives and alkalies in existence, with little benefit. She was given one teaspoonful of the fluid extract of *grindelia robusta* every two or three hours, or more frequently when her cough was troublesome. Under this treatment the cough was less severe, the expectoration diminished, and her appetite and general health improved so that she is better now than she has been for a year.

**CASE II.**—Mrs. R. had pneumonia about eighteen months ago. She has flatness of the right lung and partial consolidation at the base of the left remaining. I treated her in the acute stage of pneumonia and am treating her now. She had many remedies given her without any benefit. I placed her under the fluid extract of *grindelia robusta*, giving her a teaspoonful every two hours. She was put on this treatment about three weeks ago, and as long as she has been under it she sleeps better, has less cough and dyspnoea, and is in all respects much better than she has been for nine months.

**CASE III.**—Has cardiac enlargement, with valvular lesions and chronic bronchitis. This patient formerly derived much benefit from the fluid extract of *gelseminum* and extract *belladonna*, but lately could not be so relieved. He was placed under the *grindelia*. In this case, as in the former, the patient was relieved in a few days. His heart trouble of course remained the same, but his bronchitis was seemingly entirely cured.

I have used this medicine also in acute attacks of pneumonia and bronchitis, but derived very little benefit from it. I think it is indicated in the chronic stages only.

*Chemical Analysis.*—One pound of *herba grindelia robusta* was exhausted with a hydro-alcoholic menstruum by percolation, and the percolate reduced by evaporation to about eight fluid ounces. The remaining liquid was treated with caustic alkali in excess, and then agitated with several times its volume of ether, the ether separated and allowed to evaporate. The oleoresinous mass thus obtained had the physical appearance of gum tolu, in odor resembling gum turpentine. By dry distillation it yielded a volatile oil, the odor of which resembled oil of turpentine. Part of the oleoresin thus obtained was treated with dilute nitric acid and filtered, the filtrate decomposed with caustic potash and agitated with ether, the ether separated and allowed to evaporate spontaneously. A solution of the mass thus obtained had a distinct alkaline reaction, and under the microscope showed well formed prismatic crystals.

The alkaline fluid from which the base and oleoresin had been extracted by means of ether, was now treated with dilute sulphuric acid, in order to obtain the organic acid present. Sulphuric acid being added until the solution had a distinct acid reaction, the acid solution was then agitated with several times its volume of ether, the ether separated and allowed to evaporate. The residue was then exhausted with distilled water, in order to separate the acid from any resinous matter that had been extracted with it by ether. The aqueous solution thus obtained had a distinct acid reaction, completely neutralizing alkalies and forming salts. The solution of these salts had a yellow color. Under the microscope the acid showed well formed acicular crystals.

Time not permitting me to make a further investigation of the acid and base of this drug at present, at some future time I will make a further chemical examination, and also upon what part of the drug its physiological and active properties depend.

## Book Reviews.

[NOTE.—All works reviewed in the pages of the CHICAGO MEDICAL JOURNAL AND EXAMINER may be found in the extensive stock of W. B. KEEN, COOKE & CO., whose catalogue of Medical Books will be sent to any address upon request.]

**CYCLOPÆDIA OF THE PRACTICE OF MEDICINE.** Edited by *Dr. H. Von Ziemssen*, Professor of Clinical Medicine in Munich, Bavaria. Vol. III. Chronic Infectious Diseases, by *Prof. Christian Bäumler*, of Erlangen; *Prof. Arnold Heller*, of Kiel; and *Prof. Otto Bollinger*, of Munich. Translated by Arthur D. Nichols, M.D., of Boston, Wm. Ashbridge, M.D., of Philadelphia, James G. Hyndman, M.D., of Cincinnati, and Edward B. Bronson, M.D., and Edward L. Keyes, M.D., of New York. Albert H. Buck, M.D., of New York, Editor of American Edition; pp. 672. Wm. Wood & Co. New York. 1875.

**LECTURES ON SYPHILIS AND ON SOME FORMS OF LOCAL DISEASE AFFECTING PRINCIPALLY THE ORGANS OF GENERATION.** By *Henry Lee*, Professor of Surgery at the Royal College of Surgeons, England, etc. Philadelphia: Henry C. Lea. 1875. Pp. 246.

In this our day, when the literature of every medical subject is rapidly multiplying, there are only two species of books valued highly by the professional reader. One class embraces the cyclopædic works—literally understood. They attempt to traverse the cycle of knowledge, attained or attainable, on the subject of which they treat. An imperfect accomplishment of the orbit detracts from their value, in proportion as the failure occurs at those points where it is particularly necessary that the object in view should be attained.

In a second class of books, less pretentious, the author is absolved from the necessity of carefully collecting the treasures which have been mined by others before him, because of the genuine value of his own contribution. It must be original, either in matter or in mode of presentation, in order to secure success.

The volumes named above belong each to one of these

classes, and judged from the standard suggested, each must be decided to be deficient in the elements which give permanent value to any work.

Over three hundred pages of the Cyclopaedia are allotted to Professor Bäumler's treatise on syphilis—space which should suffice for a condensed review of the literature of the subject. And yet, on many topics which require the most careful elucidation with a comparison of authorities, the details given are meagre in the extreme. Where the author attempts to submit original observations, we do not think the value of the treatise has been greatly enhanced.

Thus, for example, in considering the primary affection in syphilis, twenty-three pages are devoted to the discussion of the doctrines of unity and duality—a discussion in which the ideas of the two schools are very fairly presented—while but four pages are allotted to the description of the primitive lesion itself. Of these, one and one-half pages are taken up in describing the flat papule of inoculation, before the attention is directed to lesions of mucous surfaces. Here the author takes a position in which he stands nearly if not quite alone. He describes “a small, itchy vesicle upon a reddened base, or an erosion, due to the bursting of the vesicle, which could not be distinguished from the erosion resulting from a simple herpetic vesicle, such as often occurs upon the inner layer of the prepuce,” as the first thing observed after the period of incubation. Dubuc attracted considerable attention in 1874, when his article on “multiple herpetiform chancres” first appeared in the *Annales de Dermatologie et de Syphiligraphie*, but he did not then claim, nor do we know that others since his writing have claimed, that the vesicle was generally the initial stage of the initial lesion of syphilis. Neither, we think, can it be demonstrated that the superficial erosion, which is the insignificant and most common form of the earliest manifestation of the disease, results from the rupture of a minute vesicle. The smooth, polished, and often pig-

mented surface, of the color of raw ham (Swediaur) which is the first phase of many chancres, does not in any way suggest the little ulcer to be found at the base of a "simple herpetic vesicle." Minute as it is, and apparently insignificant as it is, it is fraught with intense interest to the student of the career of syphilis, and deserves a much more careful description than that accorded to the entire subject, in the volume under consideration. The various modifications of the primary sore, according as it occurs upon the os uteri in woman—so carefully delineated by Fournier—or as there is developed upon and from it the well marked forms of the ulcerating chancre, are not discussed.

The primary lesion, in several parts of the treatise, is denominated the "syphilitic initial sclerosis." There is, no doubt, sufficient confusion in the nomenclature of venereal ulcers to justify the introduction of a new name by which they can be more clearly identified, but that proposed by Bäumler wants the exactness of a definitive term. "Sclerosis" is a common but not essential feature of a primary syphilitic sore. It is in fact an accident in its development. "A chancre," says Fournier, "is indurated because it is syphilitic, not syphilitic because it is indurated." Induration is true of nineteen out of twenty infecting ulcers, but the twentieth in which it is lacking, demonstrates the fact of this misnomer.

We have referred to the deficiencies of the treatise in this particular instance, merely to indicate one of many subjects whose treatment is eminently unsatisfactory. The subjects of the syphilides, their diagnostic features and treatment, syphilis of the viscera and nervous system, and hereditary syphilis, are loosely handled and imperfectly developed. Nothing, for example, could be more disappointing to a practitioner confronted with his first case of syphilitic iritis, than to consult the single page which Prof. Bäumler has written under this title, and upon which not one word appears which gives the slightest clue to the treatment which of late years has proved so

conspicuously satisfactory, even when distinct syphilitic mata have been found upon the pupillary margin.

The latter part of the volume, which treats of infection by mineral poisons, and the diseases from migratory parasites, is well illustrated and supplies a valuable contribution to the literature of a subject which is yet, to a great extent, obscure.

The translation of the whole work has been admirably accomplished, and we can not but wish that one of the translators, at least, who has made for himself an enviable reputation as an author in syphilography, had added some chapters of his own writing. There are some typographical errors which a more careful proof-reading should have corrected, but in the general excellence of the work of the publishers, this volume is quite equal to any of its predecessors.

The Lectures on Syphilis belong to the second of the two classes of books we have described, and the key note of the work is sounded in the very first sentence of the preface: "The principal object of the present work is to illustrate some of Hunter's doctrines which the lapse of time and the dissemination of more recent views have obscured, or caused to be forgotten." This may be a praiseworthy effort, but we think it misdirected, and one not at all promising for the reputation of the author. If Mr. Henry Lee had set himself to study syphilis for its own sake, and with the single view of teaching himself and his fellows the truth respecting it, he would have accomplished vastly more good. As it is, he has looked at chancres through an Hunterian objective—never an achromatic lens, and comparing unfavorably with its rivals of to-day. The profession, the scientific world and the world at large, will ever hold in the highest reverence the name of John Hunter, but they realize the fact that the medical fledgling of 1875 knew more of the truth about syphilis than ever did John Hunter.

Mr. Henry Lee at one time attracted considerable attention by his experimental inoculations with the secretions of inflamed chancres, but we do not find that since then his efforts have contributed in any direction to the advancement of syphilology. The distortion of mental vision produced by his effort to illustrate the doctrines of Hunter has rendered the lectures on syphilis obscure and valueless to the student. The inferences drawn from the cases cited are partly conjectural and partly due to misinterpretation of clinical facts.

"The principal constitutional cause," he says, "which modifies the first appearance of a real syphilitic inoculation, is the existence of what I have, for want of a better term, called the syphilitic fever." We do not know, when we read these lines, whether to account for their apparent disingenuousness by supposing the writer to be exceptionally audacious or ignorant. But the doubt is removed on the very same page (52), where we read further, that the inoculation of common pus will, under ordinary circumstances, not produce a pustule; while "under the influence of this fever" it may give rise to it. Long before these words were penned, the doctrine of the contagiousness of all common pus, with or without fever, had been promulgated by Van Roosbroeck and demonstrated by Pick, Chauveau and others. The professor of surgery at the Royal College of Surgeons, ignorant of these facts or ignoring them (the culpability being in either case the same) has thus produced a work in which an essential error has marred almost every explanation, detail and didactic statement. It is full of crudities, and misconceptions—all resulting from a single source—the egregious folly of looking at nature in health and disease not in order to observe the truth, but to obtain some little modicum of verity which will substantiate a preconceived opinion.

We know of no value attaching to these lectures beyond the addition they furnish to the clinical material of syphilitic cases.

**EXTRA-UTERINE PREGNANCY**; its Causes, Species, Pathological Anatomy, Clinical History, Diagnosis, Prognosis, and Treatment. By *John S. Parry, M.D.*, Obstetrician to the Philadelphia Hospital, etc., etc. 276 pages. Philadelphia: Henry C. Lea. 1876.

This very excellent book is based upon an analysis of five hundred cases collected from various sources, and, for a work of its size, shows immense research, and, as far as we can judge, perfect fairness in giving credit to the multitude of authors to which it refers. After confessing that in many cases the cause of this distressing difficulty cannot be determined, the author places *previous pelvic disease* at the head of the list, as being the probable cause in many instances. Inaptitude to conception, hernia of some portion of the internal genital organs, ordinary uterine displacements, and tumors, are also mentioned as causes. The particulars of two remarkable cases are given, where, after surgical operations, openings having been made through the uteri, the fertilized ova escaped into the abdominal cavity, and pregnancy took place.

Our author objects to the "minute anatomico-pathological" classification of Dezeimeris and others, and produces one of his own. He believes that there are three species of extra-uterine pregnancy, viz., tubal, ovarian, and ventral or abdominal; each species being divided into several varieties. The three recorded cases of supposed vaginal pregnancies are carefully reviewed, and the paragraph closes with the following sentence:

"It may, therefore, be concluded that we have no reliable clinical evidence that vaginal pregnancy is possible, and that there are good reasons for believing that it can not occur."—p. 49.

The *pathological changes* (1) during the early stage, (2) during the later months of gestation, and (3) after its close, are carefully considered, occupying about forty pages of the book. It seems to be well established that in these erratic pregnancies, the uterus undergoes changes nearly similar to those taking place when the

pregnancy is normal. In regard to the formation and discharge of the decidua, three propositions are given, which may be epitomized as follows: "A decidua is always formed in extra-uterine pregnancy in the uterine cavity. It is rarely retained until completed gestation, being more frequently thrown off during the early months, with symptoms of miscarriage. Its absence, when death takes place from rupture of the cyst, is no proof that it has not been formed—it has probably been previously expelled."—p. 72.

The *symptoms* of extra-uterine pregnancy are studied under three divisions, the author giving particular importance to the signs of the first period. This stage includes the first months of pregnancy, previous to the time when the sounds of the foetal heart can be detected, and is characterized by the patient supposing herself to be pregnant, and by hypogastric, colicky pains, often so extremely violent as to produce syncope, with menorrhagia.

The symptoms during the second period, and the phenomena present after the end of the normal time of gestation, are carefully considered.

The various theories as to the cause of pains, somewhat like if not identical with those of labor at the end of normal pregnancy, are also discussed. Against the theory of Powers, proposed in 1819, that of Brown-Sequard, in 1855, of King, of Washington, D.C., in 1871, and of Clarke, of Oswego, N. Y., in 1872, our author sees "insuperable objections," and rejects them all. The cause of labor pains at the close of extra-uterine gestation is not accurately known. The theories have been numerous. There is, however, now some clinical evidence (more being necessary to establish it as absolutely certain), which makes it probable that these pains are due to contractions of the uterus.

The *termination* of an extra-uterine pregnancy, we are assured by the author, is not without interest, "whether viewed with regard to the marvellous circumstances

under which life is sometimes preserved, or the frightful rapidity with which it is destroyed in other cases." The subject is considered under the following heads: (1) Rupture of the Cyst; (2) Changes which follow Retention of the Foetus for a Long Period; and (3) Discharge of the Child through the Bowel, Bladder, Vagina, or Abdominal Wall.

The *mortality* is frightful. In the 500 recorded cases 336 died—a death rate of 67.20 per cent.

The *differential diagnosis* is considered at length, and, in view of the fact that many of our most eminent obstetricians have been misled in their examination of these cases, it is a subject that should receive our most diligent study. Extra-uterine pregnancy is liable to occur in the practice of every medical gentleman, and the careful study of 500 recorded cases by any one cannot fail to be of great service.

The consideration of *the treatment* occupies seventy-five pages of the volume, and, in addition to palliative measures, the comparative value of the following methods, during the first period, are discussed: 1, Destruction of the ovum through the system of the mother; 2, Extirpation of the foetal sac; 3, Puncture of the foetal cyst; 4, Removal of the embryo by section of the vagina with the galvanic cautery; 5, Galvanism and electricity; 5, The injection of narcotic substances into the cyst; 7, Compression of the tumor.

The last pages of the book are devoted to a consideration of the operation of gastrotomy after rupture of the cyst, which the author not only believes justifiable, but says it is "simply criminal to sit idly by and see a woman die from rupture of an extra-uterine foetal cyst without attempting to save her."

In a careful perusal of the volume we have noticed but a single typographical error.

In conclusion, we must say that we are proud of the book. It is a valuable addition to American medical literature. We honor the man who has so patiently

wrought out from such a vast amount of material so valuable a work, which should be in the possession of and read by every practitioner.

C. W. E.

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A SYNOPSIS OF THE SYMPTOMS OF GOUT AT THE HEART. Also, a few Practical Remarks on Epilepsy, Nervousness, and other Kindred Diseases in relation thereto. By *Eldridge Spratt*.

We have just finished a perusal of this book, and are justly amazed at its contents. At first we were inclined to believe it written by some clever fellow as a satire upon medicine, something after the manner of Le Sage, Molière *et al.*; but a more careful study, and the fact of its having reached twelve editions, lead us into a more serious train of thought, and incline us to give it a more thorough inspection. It seems to us hardly a credible fact that, at this age of medicine, and with such advances as have been made in pathology, physiology, and kindred matters, that a physician could be found—and in England too—to produce such a trashy work, with such a lack of true medical knowledge. It speaks badly for the professional *status* of its readers, and we can only hope that his confrères (as he terms them), Sieveking, Tanner, Garrod, Fuller, the late Drs. Skey, Todd, Wardrop and others, were physicians of too kind hearts, and too indulgent to wound his sensibilities by advising its suppression, before the issue of its second edition.

There is not an original idea in the whole, and it is a work of surprises and disappointments, being only relieved by the extracts from good writers, and the anatomical plate in the beginning. We do not understand how so respectable a firm as J. B. Lippincott & Co. could have been persuaded into publishing such a *muddy* and *weak* affair, giving, as it were, a *quasi* endorsement of its demerits, and for which many a professional man will not be at all thankful.

F. B. N.

## BOOKS RECEIVED.

CYCLOPÆDIA OF THE PRACTICE OF MEDICINE. Edited by *Von Ziemssen*.  
Vol. IV—Diseases of the Respiratory Organs.

DISEASES OF THE NOSE AND ITS ACCESSORY CAVITIES. By *W. Spencer Watson, F.R.C.S., Eng., B.M.* London.

SAINT BARTHOLOMEW'S HOSPITAL REPORTS. Vol. XI. Edited by *James Andrews, M.D.*, and *Thomas Smith, F.R.C.S.*

SURGERY OF THE ARTERIES. By *C. F. Mauder*, Surgeon, etc.

THE STUDENT'S GUIDE TO THE PRACTICE OF MIDWIFERY. By *D. Lloyd Roberts, M.D., M.R.C.P.* London.

A TREATISE ON THE DISEASES OF THE NERVOUS SYSTEM. By *William A. Hammond, M.D., etc.* Sixth edition.

MORTUARY EXPERIENCE OF THE MUTUAL LIFE INS. CO., of New York. From 1843 to 1874.

A MANUAL OF DISEASES OF THE EYE. By *C. Macnamara, F.C.M., etc.*

CLINICAL LECTURES ON DISEASES OF THE HEART AND AORTA. By *Geo. Wm. Balfour, M.D., St. And., F.R.C.P., Ed., etc.*

## PAMPHLETS RECEIVED.

SPECIMEN FASCICULUS OF A CATALOGUE OF THE NATIONAL MEDICAL LIBRARY. Compiled by *Dr. J. S. Billings*, Asst. Surgeon, U. S. A. HISTORICAL SKETCH OF UNION COLLEGE, Washington: Government Printing Office. 1876.

## Medical News and Items.

ILLINOIS STATE MEDICAL SOCIETY.—The Twenty-sixth Annual Meeting of this Society will be held in Urbana, Champaign County, May 16th, at 10 o'clock A. M.

AMERICAN MEDICAL ASSOCIATION.—The 27th Annual Session will be held in the city of Philadelphia, Pa., on Tuesday, June 6, 1876, at 11 A.M.

“The delegates shall receive their appointment from permanently organized State Medical Societies, and such County and District Medical Societies as are recognized by *representation in their respective State Societies*, and from the Medical Department of the Army and Navy of the United States.”

“Each State, County, and District Medical Society entitled to representation shall have the privilege of send-

ing to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number; *Provided*, however, that the number of delegates for any particular State, territory, county, city or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association."

☒ Secretaries of Medical Societies as above designated are earnestly requested to forward, *at once*, lists of their delegates, in order that the Committee of Arrangements may be enabled to form some idea of the number likely to be present.

#### SECTIONS.

"The chairmen of the several sections shall prepare and read in the general sessions of the Association, papers on the advances and discoveries of the past year in the branches of science included in their respective sections. \* \* \*"—*By-Laws*, Art. II., Sect. 4.

Practice of Medicine, *Materia Medica*, and Physiology: Dr. Francis G. Smith, Philadelphia, Pa., Chairman; Dr. B. A. Vaughan, Columbus, Miss., Secretary. Committee appointed to report to this Section—On Clinical Observations: Dr. N. S. Davis, Ill., Chairman; Dr. H. A. Johnson, Ill.; Dr. J. B. Johnson, Mo.

Obstetrics and Diseases of Women and Children: Dr. S. C. Busey, Washington, D. C., Chairman; Dr. Robert Battey, Atlanta, Ga., Secretary. Committee appointed to report to this Section—On the Connection of the Hepatic Circulation with Uterine Hyperæmias, Fluxions, and Inflammations: Dr. L. F. Warner, Mass.

Surgery and Anatomy: Dr. Alonzo Garcelon, Lewiston, Me., Chairman; Dr. E. T. Easley, Dallas, Texas, Secretary.

Medical Jurisprudence, Chemistry, and Psychology: Dr. E. Lloyd Howard, Baltimore, Md., Chairman; Dr. V. L. Hurlbut, Chicago, Ill., Secretary.

State Medicine and Public Hygiene: Dr. R. C. Kedzie, Lansing, Mich. Chairman; Dr. Ezra M. Hunt, Metuchen, N. J., Secretary. Committee to report to this Section—On Form of Bill to Establish a National Department of Public Health at Washington: Dr. H. B. Baker, Mich., Chairman; Dr. H. A. Johnson, Ill.; Dr. J. M. Toner, D. C.

☒ "Papers appropriate to the several sections, in order to secure consideration and action, must be sent to the Secretary of the appropriate section at least one month before the meeting which is to act upon them. It shall be the duty, of the Secretary to whom such papers are sent, to examine them with care, and, with the advice of the Chairman of his section, to determine the time and order of their presentation, and give due notice of the same. \* \* \*"—*By-Laws*, Art. II, Sect. 5.

The following Committees are expected to report: On Mechanism of Accommodation of the Eye: Dr. D. S. Reynolds, Ky., Chairman.

On New Remedies: Dr. Austin Flint, Jr., N. Y., Chairman.

On the Medical and Surgical Uses of the Aspirator: Dr. E. S. Gaillard, Ky., Chairman.

On Influence of Climate on Pulmonary Diseases in Minnesota: Dr. Franklin Staples, Minn., Chairman.

On the same in Colorado: Dr. Chas. Denison, Col., Chairman.

On the same in Florida: Dr. E. T. Sabal, Fla., Chairman.

On Proper Legislation to Prevent the Spread of Syphilis: Dr. Samuel D. Gross, Pa., Chairman.

On Prize Essays: Dr. Samuel D. Gross, Pa., Chairman.

On Necrology: Dr. S. C. Chew, Md., Chairman.

On Rank of Medical Corps of the Army: Dr. H. A. Johnson, Ill., Chairman.

W. B. ATKINSON, *Permanent Sec'y.*

PHILADELPHIA, 1400 Pine St., S. W. cor. Broad.

**CHICAGO MEDICAL PRESS ASSOCIATION.**—The Directors wish to express thanks for the following books received. From Dr. Philip Adolphus, Chicago, 44 vols., as follows:

Cooper's Lectures.	Andral on the Blood in Disease.
Howship on the Rectum.	Philip on Acute and Chronic Diseases.
Bell on Ulcers.	Beclard's General Anatomy.
Cooper's Surgery, 2 vols.	Bell's Anatomy, 3 vols.
Strohmeyer & Eshmarch on Gun Injuries.	Parson's Anatomical Preparations.
Guthrie, Military Surgery.	Brechard's Physiological Researches.
Carmichael on Venereal.	Broussais' Physiology.
Cazenave on the Skin.	Wilson on Vital Functions.
Bateman, Synopsis of Venereal Diseases.	Blumenbach's Physiology.
Travers on Irritation.	Richenad's Physiology.
Rogerson on Inflammation.	Beain's Therapeutics.
Andral on Chest Diseases.	Paris' Pharmacologia.
Andral, Diseases of Abdomen.	Ellis' Medical Formulary.
Abercrombie on the Brain.	Paris on Diet.
Abercrombie on the Stomach.	Combe on Infancy.
Budd on the Liver.	Althaus' Medical Electricity.
Armstrong on Typhus Fever.	Brand and Taylor's Chemistry.
Ayre on Dropsey.	Brodie on Joints.
Armstrong on Fevers.	Prout on Calculus.
Andral on the Encephalon.	Report of Board of Health of Chicago for 1867-9.
Bichat on Pathological Anatomy.	

Also the following books and pamphlets from Dr. Hamill:

Principal Diseases of the Valley of North America. 1849. D. Drake, M.D. 1 vol.

Second Series Principal Diseases of the Valley of North America. 1850. D. Drake, M.D. 1 vol.

American Journal Medical Sciences for 1844-5. 4 vols. in 2.

Principles of Pathology and Practical Physic. By John Mackintosh. Edition 1887. 2 vols.

Bell and Stokes. 10 vols. Gooch on Females. 1832. 1 vol.

Art of Preventing Disease and Restoring Health. By Geo. Wallis, M.D., S.M.S. 1794. 1 vol.

Western Journal Medical Science for 1834-5. Transactions American Medical Association for those years. 1 vol.

Combe's System of Phrenology. 1 vol.

Medical and Surgical History of the War of the Rebellion: Surgeon Barnes' Report. 1870. 2 vols.

Cholera Epidemic of 1873 in the United States. J. M. Woodworth, M.D. 1 vol.

Circular of War Department by Surgeon Barnes. 1870. 1 vol.

Statistics—Population. 1870. 1 vol.

Mortuary Statistics. 1860. 1 vol.

Population Statistics. 1860. 1 vol.

Vital Statistics. 1870. 1 vol.

Population Statistics. 1870. 1 vol.

Wister's Anatomy. 1835. 2 vols.

Library of Practical Medicine. 1832. 1 vol.

Thompson's *Conspicuous*. 1846. 1 vol.

#### PAMPHLETS.

Chicago Medical Journal for 1868-9. 2 vols.

Medical Examiner for 1868-9-70-71-72-73-74-75.

Transactions of Illinois State Med. Society for 1860-64-67-68-69-70-71-74.

And sundry Medical Journals.

### ANNOUNCEMENTS FOR THE MONTH.

#### MONDAYS. SOCIETIES.

*Mondays, May 1 and 15*—Chicago Med. Society, regular meetings at the Washingtonian Home, 8 P.M.

*Mondays, May 8 and 22*—Chicago Society of Physicians and Surgeons, regular meetings at Grand Pacific, 8 P.M.

#### CLINICS. Every Monday.

At Eye and Ear Infirmary, (Peoria and Adams Sts.) 2 P.M.—Prof. Holmes.

At Central Dispensary (239 W. Van Buren St.), 2 P.M., *Gynecological*—Dr. Adolphus; 3 P.M., *Medical*—Dr. Bridge.

At Mercy Hospital, 2 P.M., *Medical*—Prof. Johnson.

#### TUESDAYS. SOCIETIES.

*Tuesday, May 9*—Academy of Sciences, regular meeting, 8 P.M. (263 Wabash Ave).

#### CLINICS. Every Tuesday.

At County Hospital, 2 P.M., *Medical*—Prof. Lyman; 3 P.M., *Surgical*—Prof. Freer.

At Mercy Hospital, 2 P.M., *Medical*—Prof. Hollister.

#### WEDNESDAYS. CLINICS. Every Wednesday.

At County Hospital, 2 P.M., *Ophthalmological*—Dr. Montgomery; 3 P.M., *Gynecological*—Prof. Quine.

At Mercy Hospital, 2 P.M., *Surgical*—Prof. Andrews.

At Central Dispensary, 2 P.M., *Medical*—Dr. Bridge.

At St. Luke's Hospital, commencing at 1:30 P.M., *Surgical*—Dr. Owens.

#### THURSDAYS. CLINICS. Every Thursday.

At Central Dispensary, 2 P.M., *Diseases of Chest*—Dr. Ingals.

At Mercy Hospital, 2 P.M., *Medical*—Prof. Johnson.

#### FRIDAYS. SOCIETIES.

*Friday, May 12*—State Microscopical Society of Illinois, regular meeting at the Academy of Sciences, 8 P.M.

#### CLINICS. Every Friday.

At County Hospital, 2 P.M., *Medical*—Prof. Lyman; 3 P.M., *Surgical*—Prof. Freer.

At Mercy Hospital, 2 P.M., *On Diseases of Eye and Ear*—Prof. Jones.

At Central Dispensary, 2 P.M., *Gynecological*—Dr. Adolphus.

#### SATURDAYS. CLINICS. Every Saturday.

At Rush College, 2 P.M., *Surgical*—Prof. Gunn; 3 P.M., *Diseases of the Brain and Nervous System*—Dr. Hay.

At Chicago College, 2 P.M., *Surgical*—Prof. Andrews; 3 P.M., *Medical*—Prof. Davis.

At all the above Clinics visiting regular practitioners are, we believe, admitted.